TEXT INTEGRATION UTILITIES (TIU)

CLINICAL COORDINATOR & USER MANUAL

Version 1.0

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Department of Veterans Affairs
***V**ISTA* System Design & Development
Computerized Patient Record System Product Line

Revision History

Originally released		July 1997
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Preface

Purpose of Text Integration Utilities

Text Integration Utilities (TIU) simplifies the access and use of clinical documents for both clinical and administrative VAMC personnel, by standardizing the way clinical documents are managed. In connection with Authorization/Subscription Utility (ASU), a hospital can set up policies and practices for determining who is responsible or has the privilege for performing various actions on required VHA documents.
The initial release of Version 1.0 includes Discharge Summary and Progress Notes. TIU replaces and upgrades the previous versions of these **V***IST***A** packages.

Scope of Manual

This manual provides descriptions of menus and options, as well as other information required to effectively use the Text Integration Utilities package.

Audience

Information in this manual is intended for Clinical Coordinators, Automated Data Processing Application Coordinators (ADPACs), and end users: clinicians, MIS Managers, Medical Record Technicians, and transcriptionists.

Related Manuals

Text Integration Utilities (TIU) Implementation Guide
Text Integration Utilities & Authorization/Subscription Utility Installation Guide
Text Integration Utilities (TIU) Technical Manual
Authorization/Subscription Utility (ASU) User Manual

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Chapter 1: Introduction to TIU

Purpose of Text Integration Utilities

The purpose of Text Integration Utilities (TIU) is to simplify the access and use of clinical documents for both clinical and administrative VAMC personnel, by standardizing the way clinical documents are managed. In connection with Authorization/ Subscription Utility (ASU), a hospital can set up policies and practices for determining who is responsible or has the privilege for performing various actions on required VHA documents.

The initial release of Version 1.0 includes Discharge Summary and Progress Notes. Consult Reports was added with the release of Computerized Patient Record System (CPRS). TIU replaces and upgrades the previous versions of these **V*IST*A** packages. It has also been designed to meet the needs of other clinical applications that address document handling.

TIU lets you continue to access Progress Notes and Discharge Summaries from OE/RR menus. The CPRS Graphical User Interface (GUI) allows point-and-click access to all Progress Notes, Discharge Summaries, and Consults TIU documents.

Benefits

a. Standardized and common user interface

Clinicians can go through the same program to enter, review, and sign discharge summaries, progress notes, and other clinical documents that may be set up locally for processing through TIU.

b. Integration

Clinicians and management can search for and retrieve clinical documents more efficiently because documents reside in a single location within the database. This is also a benefit for other uses such as Incomplete Record Tracking, quality management, results reporting, order checking, research, etc.

c. Data Capture Flexibility

TIU accepts document input from a variety of data capture methodologies. Those initially supported are transcription and direct entry. TIU allows upload of ASCII formatted documents into **V*IST*A**.

Benefits, cont'd

d. Links to Other Packages.

TIU interfaces, as appropriate, with such applications as Health Summary, Problem List, Patient Care Encounter/Visit Tracking, and Incomplete Record Tracking. Computerized Patient Record System (CPRS) further integrates **V*IST*A** packages and allows point and click switching between packages.

A new Health Summary component is available (through Patch GMTS*2.7*12), *Selected Progress Notes*, which allows selection of specific Progress Notes Titles for display on Health Summaries. The PN, DS, and CWAD components now extract data from TIU, rather than Progress Notes (GMRP), or Discharge Summary (GMRD). Care has been taken to assure that the formatting and content of the components have remained the same, except that the signature block information will now reflect the author's (and cosigner's) name and title at the time of signature, rather than displaying their current values at the time of output.

e. Improved management of Documents.

TIU has a file structure called the Document Definition Hierarchy for defining elements and parameters of a document. It allows

- Inheritance of document characteristics, such as signing, cosigning, visit linkage, etc.
- Site definition of document characteristics
- Shared components
- Ownership (personal or class) of document definitions
- Boilerplate text functionality
- Interdisciplinary Note functionality.
- Embedded "Object" functionality which can extract data from other**V*IST*A** packages and insert it into boilerplate text

Chapter 2: Orientation

Manual organization

This manual is divided into four major sections:

Section	Purpose
I: Introduction	Presents overviews of TIU software and the User Manual.
II: Using TIU	Describes and demonstrates how to use the basic entry and reporting functions of TIU. This section is divided into sub-sections for the four major users of TIU: clinicians, MRTs, MIS Managers, and transcriptionists
III: Managing TIU	Describes the options and tools available to coordinato and IRMS for assigning menus, setting parameters, an other management functions. Also includes Troubleshooting and Helpful Hints.
Glossary and Index	Definitions of terms and the index to the manual.

How each chapter is formatted

Each chapter generally follows the format of:

- Brief overview
- Description of process (step-by-step description of how to use functions, if appropriate)
- Examples

Online documentation: Intranet

Online Documentation for this product is available on the intranet at the following address:
http://vista.med.va.gov/softserv/clin_bro.ad/desktop.htm
This address takes you to the Clinical Products page, which has a listing of all the clinical software manuals. Click on the Text Integration Utilities link and it will take you to the TIU Homepage.
You can also get there by going straight to the following address:
vista.med.va.gov/tiu

☞ Remember to bookmark this site for future reference.

Special Instructions for the new V*ISTA* Computer User

If you are unfamiliar with this package or other Veterans Health Information Systems and Technology Architecture (**V*ISTA***) software applications, we recommend that you study the DHCP *User's Guide to Computing.* This

orientation guide is a comprehensive handbook for first-time users of any **V*IST*A** application to help you become familiar with basic computer terms and the components of a computer. It is reproduced and distributed periodically by the Kernel Development Group. To request a copy, contact your local Information Resources Management Service (IRMS) staff.

Graphic Conventions Used in This Manual

<Enter>
The Enter or Return key**.** It is pressed after every response you enter or when you wish to bypass a prompt, accept a default (//), or return to a previous action. In this manual, it is only included in examples when it might be unclear that such a keystroke must be entered.

Option examples
Menus and examples of computer dialogue that you see on the screen are shown in boxes:

```
Select Menu Option:
```

User responses
User responses are shown in **boldface**.

```
Select PATIENT NAME: GRIN,JON
```

☞ **NOTE**
The pointing finger with a NOTE is used to call your attention to something especially significant.

Example:

☞ **NOTE**: You can respond to many prompts by typing the first few letters of a name, option, or action.

```
Select PATIENT NAME: GRI      GRIN,JON
```

^ , ^^, ^^^

Enter the up-arrow (also known as a caret or circumflex) at a prompt to exit the current option, menu, sequence of prompts, or help. To get completely out of your current context and back to your original menu, you may need to enter two or three up-arrows. For example, when you're reviewing a list of documents, one up-arrow takes you to the next document; you need to enter two up-arrows to get out of the option.

> >

TIU screens can contain more information to the right of the main screen display. To see this information, enter the > character. To return to the main screen, enter the < character.

☞ **NOTE**: The arrow keys on the keypads of some keyboards can sometimes be used for navigation in List Manager applications, but this depends on the operating system. So if you get funny characters on your screen when you use those arrows, use the > and < symbols on the comma and period keys (the greater-than and less-than symbols).

Online Help ?, ??, ???

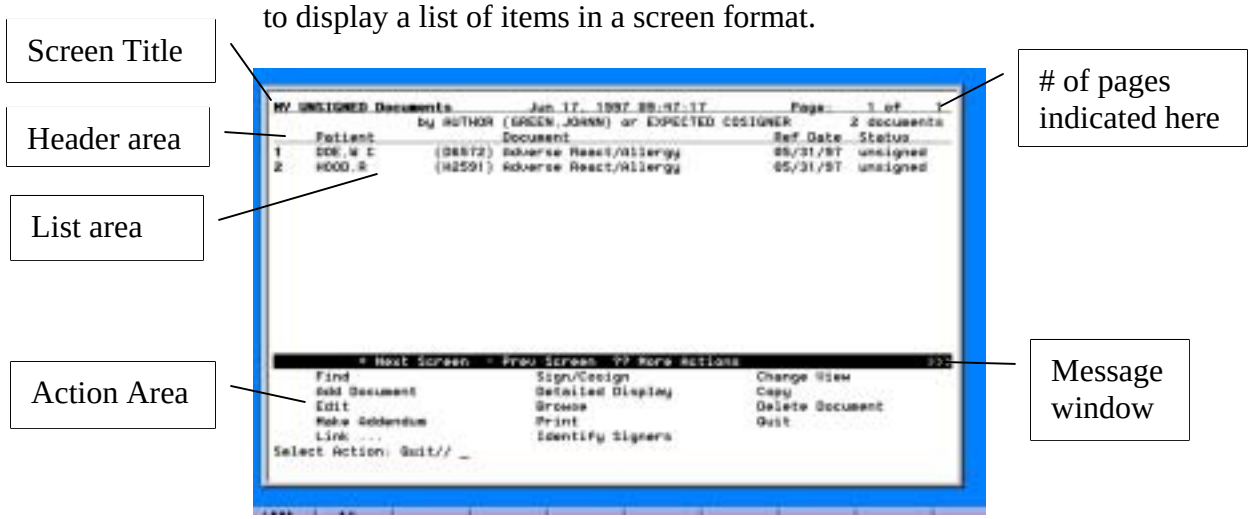
Online help is available by entering one, two, or three question marks at a prompt. One question mark elicits a brief statement of what information is appropriate for responding to the prompt; two question marks shows a list (and sometimes descriptions) of more actions; and three question marks provide more detailed help, including a list of possible answers, if appropriate.

Defaults (//) Defaults are responses provided to speed up your entry process. They are either the most common responses, the safest responses, or the previous response. Examples:

Most common:	Enter the ending date: NOW//
Safest:	Do you wish to delete the entire entry: NO//
Last entered	Enter the Provider Name: WELBY,DOCTOR//

List Manager Screen Display

TIU uses the List Manager utility which enables TIU (and other applications) to display a list of items in a screen format.



Screen title
The screen title changes according to what type of information List Manager is displaying (e.g., Progress Notes, Discharge Summary, etc.).

Header area
The header area is a “fixed” (non-scrollable) area that displays patient information.

List area
(scrolling region) This area scrolls if there are more items than will fit on one page. It displays a list of items, such as Unsigned Progress Notes, that you can take action on. If there’s more than one page of items, it’s listed in the upper right-hand corner of the screen (Page 1 of #).

Message window
This section displays a plus (+) sign, minus (-), or >> sign, or informational text (i.e., Enter ?? for more actions). If you enter a plus sign at the action prompt, List Manager “jumps” forward a page. If a minus sign is displayed and you enter it at the action prompt, List Manager “jumps” back a screen. The plus, minus, and > signs are only valid actions if they are displayed in the message window.

List Manager Screen Display cont'd

Action area
A list of actions display in this area of the screen. If you enter a double question mark (??) at the "Select Item(s)" prompt, you are shown a "hidden" list of additional actions that are available to use.

Entering Actions

The List Manager utility lets you:
- browse through the list
- select items that need action
- take action against those items
- select other actions without leaving the option

Actions are entered by typing the name or abbreviation at the "Select Action" prompt.

Shortcut: Actions may also be preselected by typing the action abbreviation, then the number of the document on the list (Example: ED=1 will let you edit entry 1, Consult Report.

Besides the actions specific to the option you are working in, List Manager provides generic actions applicable to any List Manager screen. Enter a double question mark (??) at the "Select Action" prompt for a list of all actions available. The abbreviation for each action is shown in brackets following the action name. These actions are described on the next page.

List Manager Screen Display, cont'd

Generic (hidden) actions

Action	Description
Next Screen [+]	Move to the next screen (may be shown as a default)
Previous Screen [-]	Move to the previous screen
Up a Line [UP]	Move up one line
Down a Line [DN]	Move down one line
Shift View to Right [>]	Move the screen to the right if the screen width is more than 80 characters
Shift View to Left [<]	Move the screen to the left if the screen width is more than 80 characters
First Screen [FS]	Move to the first screen
Last Screen [LS]	Move to the last screen
Go to Page [GO]	Move to any selected page in the list
Re Display Screen [RD]	Redisplay the current screen
Print Screen [PS]	Prints the header and the portion of the list currently displayed
Print List [PL]	Prints the list of entries currently displayed
Search List [SL]	Finds selected text in list of entries
Auto Display (On/Off) [ADPL]	Toggles the menu of actions to be displayed/not displayed automatically
Change Title (CT)	Lets you change the Title of a note from, e.g., a CWAD note to a Nursing Note
CWAD Display (CWAD)	Displays details of any CWAD notes available
Quit [QU]	Exits the screen (may be shown as a default)

Section 2: Using TIU

Chapter 3: TIU for Clinicians

- **Progress Notes/Discharge Summary Menu**
- **Using Progress Notes through OE/RR 2.5 or CPRS 1.0**
- **Progress Notes Options**
- **Progress Notes Actions and Statuses**
- **Interdisciplinary Notes Actions**
- **Discharge Summary Options**
- **Discharge Summary Actions and Statuses**
- **Integrated Document Management Options**
- **Personal Preferences**
- **Document Definitions**
- **TIU and Health Summary**

Chapter 3: TIU for Clinicians

Progress Notes/Discharge Summary Menu

This is the main TIU menu for clinicians. It includes all of the options necessary for clinicians to manage their Progress Notes, Discharge Summaries, and other clinical documents which may be set up locally, either separately or in an integrated fashion. TIU also lets you continue to access Progress Notes and Discharge Summaries through OE/RR menus. CPRS allows point and click access to all Progress Notes, Discharge Summaries, and Consults TIU documents.

The Progress Notes/Discharge Summary (TIU) menu also includes a Personal Preferences menu that lets clinicians change their own parameters for viewing clinical documents.

Option Name	Description
Progress Notes User Menu	This menu includes options for reviewing, entering, printing, and signing progress notes, either by individual patient or by multiple patients.
Discharge Summary User Menu	This menu includes options for reviewing, entering, printing, and signing discharge summaries, either by individual patient or by multiple patients.
Integrated Document Management	This menu lets clinicians perform actions on progress notes, discharge summaries, and other clinical documents from a single menu For example, a clinician may want to bring up all his unsigned documents.
Personal Preferences	This menu allows users to 1) enter preferences about the behavior of the TIU Package. These preferences include: DEFAULT LOCATION, REVIEW SCREEN SORT FIELD SORT ORDER DISPLAY MENUS PATIENT SELECTION PREFERENCE 2) specify “pick lists” for document selection when composing or editing documents (e.g., when choosing documents from the class Progress Notes, “Let me see these three specific titles”).

Using Progress Notes through OE/RR 2.5 or CPRS

Clinicians who enter and review Progress Notes through OE/RR 2.5 will also be able to do so with TIU. CPRS (Computerized Patient Record System) access to and operations on Progress notes is screamlined. Here we give an example of reviewing Notes through the List Manager version of CPRS. The GUI version has a different sequence of steps, but should seem even easier to most people.

Example: Reviewing and signing Notes through CPRS

1. Select the Clinician Menu from your CPRS menu.

```
   OE     CPRS Clinician Menu
   RR     Results Reporting Menu
   AD     Add New Orders
   RO     Act On Existing Orders
   PP     Personal Preferences ...
Select Clinician Menu Option: OE  CPRS Clinician Menu
```

2. The Patient Selection screen is displayed. If you have a patient or team list defined, the patients are on this display.

```
Ward 2B                          Mar 17, 1997 17:07:09      Page:   1 of    1
Current patient: ** No patient selected **

     Patient Name                      ID        DOB             Room-
Bed
1    ANDERSON,H C                      (3456)    Jan 01, 1951
2    BUD,ROSE                          (1996)    Mar 05, 1949
3    DINARO,MUCHO                      (3779)    Nov 19, 1991
4    ESSTEPON,GLORD                    (3234)    Mar 03, 1966
5    GRETSKI,DWAYNE                    (2432)    Apr 04, 1932
6    HOOD,ROBIN                        (2591)    Apr 25, 1931    9-B
7    JINGLE,BELLS                      (8910)    Jan 01, 1934    A-4
8    NEWTON,JUICE                      (3243)    Apr 04, 1954
9    NIVEK,EPSILON                     (4723)    Oct 23, 1927    A-2

Enter the number of the patient chart to be opened
+   Next Screen           CG  Change List ...       FD  Find
Patient
-   Previous Screen       SV  Save as Default List  Q   Close
Select Patient: Close// 1        ANDERSON,H C
Searching for the patient's chart ...
```

If you have a patient list defined in your personal preferences it is displayed here. If not, just enter a

3. Select a patient by:

- Entering a name from a list (if you have one defined and set as your default
- Entering a patient's name (or last initial + last 4 letters of SSN)
- Entering FD (Find Patient), entering a ward or clinic name, then selecting a patient name from the list that appears.

Example: Reviewing Notes, cont'd

4. The "Cover Sheet" for the patient's record is displayed. Select Chart Contents.

```
Cover Sheet                    Mar 17, 1997 17:07:50        Page:  1 of    2
ANDERSON,H C   321-12-3456              2B            JAN 1,1951 (46)   <CW>

     Item                                                Entered
     Allergies/Adverse Reactions                        |
 1   PENICILLIN 1 (rash, nausea,vomiting)               | 01/03/97
                                                        |
     Patient Postings                                   |
2    CRISIS NOTE                                        | 02/24/97 08:28
3    CRISIS NOTE                                        | 12/03/96 10:44
4    CLINICAL WARNING                                   | 02/21/97 09:16
5    CLINICAL WARNING                                   | 01/15/97
                                                        |
     Recent Vitals                                      |
     No data available                                  |
                                                        |
     Immunizations                                      |
     No immunizations found.                            |
                                                        |
+       Enter the numbers of the items you wish to act on.              >>>
NW  Document New Allergy  CG  (Change List ...)     SP  Select New Patient
+   Next Screen           CC  Chart Contents ...    Q   Close Patient Chart

Select: Next Screen// cc   CHART CONTENTS
```

Shortcut: Enter CC;N to bypass the next screen.

5. A new set of actions is displayed. These are the Contents or categories of the Patient Chart (also known as "Tabs.") Select the Notes tab.

```
Cover Sheet                    Mar 17, 1997 17:07:50        Page:  1 of    2
ANDERSON,H C   321-12-3456              2B            JAN 1,1951 (46)   <CW>

     Alert                                               Entered
     Allergies/Adverse Reactions                        |
1    PENICILLIN 1 (rash, nausea,vomiting)               | 01/03/97
                                                        |
     Patient Postings                                   |
2    CRISIS NOTE                                        | 02/24/97 08:28
3    CRISIS NOTE                                        | 12/03/96 10:44
4    CLINICAL WARNING                                   | 02/21/97 09:16
5    CLINICAL WARNING                                   | 01/15/97
                                                        |
     Recent Vitals                                      |
     No data available                                  |

+       Enter the numbers of the items you wish to act on.              >>>
  Cover Sheet          Orders              Imaging              Reports
  Problems             Meds                Consults
  Notes                Labs                D/C Summaries
Select chart component: N   Notes
Searching for the patient's chart ...
```

Example: Reviewing Notes, cont'd

6. The patient's completed progress notes are displayed. This is the default set up through Personal Preferences. You can "change view" to see a different status, such as unsigned notes.

```
Completed Progress Notes      Mar 17, 1997 17:10:56        Page:  1 of  1
ANDERSON,H C   321-12-3456             2B          JAN 1,1951 (46)   <CW>

     Title                                      Written          Sig Status
1    CRISIS NOTE                              | 02/24/97 08:28   completed
2    CLINICAL WARNING                         | 02/21/97 09:16   completed
3    General Note                             | 01/24/97 14:18   completed
4    CLINICAL WARNING                         | 01/15/97         completed
5    SOAP - GENERAL NOTE                      | 12/04/96 14:39   completed
6    SOAP - GENERAL NOTE                      | 12/04/96 11:32   completed
7    CRISIS NOTE                              | 12/03/96 10:44   completed
8    SOAP - GENERAL NOTE                      | 12/03/96 10:31   completed
9    SOAP - GENERAL NOTE                      | 11/22/96 12:37   completed




      Enter the numbers of the items you wish to act on.              >>>
NW  Write New Note        CG  Change List ...     SP  Select New Patient
+   Next Screen           CC  Chart Contents ...  Q   Close Patient Chart

Select: Chart Contents// CG   CHANGE LIST
 Date range                Status
```

```
Select attribute(s) to change: S   STATUS
Select Signature Status: completed//??

Enter the signature status you would like to screen on
Choose from:
   amended
   completed
   deleted
   purged
   uncosigned
   undictated
   unreleased
   unsigned
   untranscribed
   unverified

Select Signature Status: completed//UNSigned
Searching for the patient's chart ...
```

Example: Reviewing Notes, cont'd

7. The patient's unsigned notes are displayed.

```
Unsigned Progress Notes        Mar 17, 1997 17:13:22       Page:   1 of    1
ANDERSON,H C   321-12-3456              2B            JAN 1,1951 (46)    <CW>

     Title                                            Written         Sig Status
1    Addendum to CLINICAL WARNING                   | 01/28/97         unsigned




         Enter the numbers of the items you wish to act on.                >>>
NW  Write New Note          CG  Change List ...        SP  Select New Patient
+   Next Screen             CC  Chart Contents ...     Q   Close Patient Chart

Select: Chart Contents//
```

Example: Writing a note

```
Select: Chart Contents// NW   Write New Note
Available note(s):  11/22/96 thru 02/24/97  (9)
Do you wish to review any of these notes? NO// YES
```

```
                       --- Select note(s) to review ---

Please specify a date range from which to select note(s):
List Notes Beginning: 11/22/96//<Enter>   (NOV 22, 1996)
                Thru: 02/24/97//<Enter>   (FEB 24, 1997)

1   02/24/97 08:28  CRISIS NOTE                              JON GRIN
                      Adm: 09/21/95
2   02/21/97 09:16  CLINICAL WARNING                         TAN DEM
                      Adm: 09/21/95
3   01/24/97 14:18  General Note                             Joe E. Russ
                      Adm: 09/21/95
    SUBJECT: TEST
4   01/15/97 00:00  CLINICAL WARNING                         Doogey Howser, MD
                    Visit: 08/14/95
5   12/04/96 14:39  SOAP - GENERAL NOTE                      Joe E. Russ
                      Adm: 09/21/95
Choose Notes:  (1-5): <Enter>

Nothing selected.
```

Example: Writing a note, cont'd

```
Personal PROGRESS NOTES Title List for JON GRIN
   1    Crisis Note
   2    Advance Directive
   3    Adverse Reactions
   4    Other Title
TITLE:  (1-4): 3    Adverse React/Allergy

Creating new progress note...
          Patient Location:  2B
   Date/time of Admission:  09/21/95 10:00
         Date/time of Note:  NOW
            Author of Note:  GREEN,JOANN
   ...OK? YES// <Enter>

SUBJECT (OPTIONAL description):
Calling text editor, please wait...
  1>TEST
  2> <Enter>
EDIT Option:
Save changes? YES// <Enter>

Saving Adverse React/Allergy with changes...
Enter your Current Signature Code: XXX   SIGNATURE VERIFIED..
Print this note? No// YES
Do you want WORK copies or CHART copies? CHART//<Enter>
DEVICE: HOME// <Enter>  VAX
```

```
------------------------------------------------------------------------
ANDERSON,H C  321-12-3456                                 Progress Notes
------------------------------------------------------------------------
NOTE DATED: 03/17/97 17:15    ADVERSE REACT/ALLERGY
ADMITTED: 09/21/95 10:00 2B
TEST

                  Signed by: /es/ JON GRIN
                                  JON GRIN 03/17/97 17:15
Enter RETURN to continue or '^' to exit: <Enter>

You may enter another Progress Note. Press RETURN to exit.
Select PATIENT NAME: <Enter>
```

Select Search through CPRS

You can narrow your view to signed notes by author, unsigned notes, etc. You can also specify the date order your notes will appear in: ascending (oldest first) or descending (most recent first) order.

☞ **Caution:** Avoid selecting too large a date range or too general a category, as big searches are very system-intensive. This means that not only might it slow down your work, but everyone else's as well.

```
Progress Notes              Apr 09, 1997 14:42:58          Page:     1 of    1
<CWA>                          P R O G R E S S   N O T E S          Last 15 note(s)
ANDERSON,H C          321-12-3456  2B/                              JAN 1,1951 (46)
       Title                                  Author           Date/Time
1      Psychology Notes                    RUSS,J          04/08/97 15:49     compl
2      CRISIS NOTE                         HOWSER,D        04/08/97 00:00     compl
3      Adverse React/Allergy               GRIN,J          04/07/97 16:28     compl
6      Adverse React/Allergy               GRIN,J          04/03/97 19:31     compl
7      Adverse React/Allergy               GRIN,J          03/17/97 17:15     compl
8      CRISIS NOTE                         GRIN,J          02/24/97 08:28     compl
                                                                              
NW   New Note              SP   Select New Patient   AD   Make Addendum
B    Browse                SS   Select Search        $    Complete Note(s)
PC   Print Copy            RS   Reset to All Signed  Q    Quit
Select Action: Quit// SS   Select Search
```

```
Valid selections are:
  1 - signed notes (all)   2 - unsigned notes       3 - uncosigned notes
  4 - signed notes/author  5 - signed notes/dates

Select context: 1// 4  AUTHOR
Select AUTHOR: GRIN,JON// <Enter>          jg
Please Specify Sort Order: descending// ?
Enter a code from the list.
Select one of the following:
          A         ascending (OLDEST FIRST)
          D         descending (NEWEST FIRST)
Please Specify Sort Order: descending//  A  ascending (OLDEST FIRST)
Searching for the progress notes.
```

```
Progress Notes              Apr 09, 1997 14:42:50          Page:    1 of    1
<CWA>                          P R O G R E S S   N O T E S          4 note(s)
ANDERSON,H C          321-12-3456  2B/                              JAN 1,1951 (46)
       Title                                  Author           Date/Time
1      CRISIS NOTE                         GRIN,J          02/24/97 08:28     compl
2      Adverse React/Allergy               GRIN,J          03/17/97 17:15     compl
3      Adverse React/Allergy               GRIN,J          04/03/97 19:31     compl
4      Adverse React/Allergy               GRIN,J          04/07/97 16:05     compl

        + Next Screen      - Prev Screen          ?? More Actions
NW   New Note              SP   Select New Patient   AD   Make Addendum
B    Browse                SS   Select Search        $    Complete Note(s)
PC   Print Copy            RS   Reset to All Signed  Q    Quit
Select Action: Quit//
```

Progress Notes Options

Clinicians can review, enter, print, and sign progress notes, either by individual patient or by multiple patients, through TIU.

☞ **NOTE:** When reviewing several notes sequentially, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

Clinician's Progress Notes Menu

Option	Description
Entry of Progress Note	This is the main option for entering a new progress note. You can also edit patient progress notes.
Review Progress Notes by Patient	This option lets you review, edit, or sign a selected patient's progress notes, by selected criteria.
Review Progress Notes	This option lets clinicians get quickly to a patient's list of notes, without preliminary prompts to select criteria for displaying notes.
All MY UNSIGNED Progress Notes	This option retrieves all your unsigned progress notes for review, edit, or signature.
Show Progress Notes Across Patients	This option lets you search for and review progress notes by many different criteria: status, type, date range, and category. **Caution:** Avoid selecting too large a date range or too general a category, as big searches are very system-intensive. This means that not only might it slow down your work, but everyone else's as well.
Progress Notes Print Options ...	The options on this menu support the printing of chart or work copies, by author, location, patient, or ward. These options are described in Chapter 8.
List Notes By Title	This option lets you look up progress notes by title within a specified date range.
Search by Patient AND Title	This option lets you search for and review progress notes by patient, as well as many other criteria: status, type, date range, and category.
Personal Preferences...	The two options on this menu let you customize the way TIU operates for you; that is, which prompts will appear, what lists you will see to select from, etc. You can also specify the way documents are displayed on your review screens, by patient, by author, by type, in chronological or reverse chronological order, etc.

Entry of Progress Note

This is the main option for entering a new progress note. You can also *edit* patient progress notes.

Example 1: Inpatient progress note

Steps to use option:

1. Select *Entry of Progress Note* from your Progress Notes Menu. If you have a patient list set up (through Personal Preferences), it is displayed here.

```
Loading Ward Patient List...
                            2B ward list

1    ANDERSON,H C      (3456) ~          8    KAPLON,DENNIS     (3242) A-4
2    APPLESEED, J      (0999) ~          9    NEWTON,JUICE      (3243) ~
3    BUD,ROSE          (1996) ~          10   NIVEK,EPSILON     (4723) A-2
4    DINARO,MUCHO      (3779) ~          11   ROM,C.D.          (3213) A-1
5    ESSTEPON,GLORD    (3234) ~          12   TURNER,TOMMY      (2342) ~
6    GRETSKI,DWAYNE    (2432) ~          13   WHITE,PAGES       (1321) A-3
7    HOOD,ROBIN        (2591) 9-B        14   ZORRO,MIGUEL      (1414) ~
```

2. Type in a patient name or a number from the list. Demographic data and CWAD (Cautions, Warnings, Adverse Reactions, and Directives) notes are displayed. You are prompted to choose if you want to see any of the previous Progress Notes for this patient.

```
Select Patient(s): 7    HOOD,ROBIN 04-25-31   603042591P     NO     MILITARY
RETIREE
             (6 notes)  W: 01/27/97 15:17  (addendum 02/08/97 17:19)
                        A: Known allergies
             (1 note )  D: 03/26/97 13:02

Available notes:  11/11/96 thru 04/15/97  (27)
Do you wish to see any of these notes? NO// <Enter>
```

This indicates that there are 27 notes for this patient.

3. **Select a Title.** If you have a personal Progress Notes title list set up through Personal Preferences, that list is displayed for you to choose from. Enter a Subject, if desired, and the text of the Progress Note.

```
Personal PROGRESS NOTES Title List for JOANN GREEN
1    Crisis Note
   2    Advance Directive
   3    Adverse Reactions
   4    Other Title
TITLE:  (1-4): 3// <Enter>
    Adverse React/Allergy

Creating new progress note...
          Patient Location:  1A
    Date/time of Admission:  05/30/97 10:43
         Date/time of Note:  NOW
            Author of Note:  GREEN,JOANN
   ...OK? YES// <Enter>
SUBJECT (OPTIONAL description): <Enter>

Calling text editor, please wait...
  1>Mr. Hood improving; renewed prescription.
  2> <Enter>
EDIT Option:
Save changes? YES// <Enter>
Saving Adverse React/Allergy with changes...
```

4. **Enter your electronic signature code.** If you wish to print the note (either a Work or Chart copy), answer yes to the next prompt, and enter a printer device name.

```
Enter your Current Signature Code: XXX   SIGNATURE VERIFIED..
Print this note? No// y  YES
Do you want WORK copies or CHART copies? CHART// w  WORK
DEVICE: HOME//<Enter>   VAX
```

5. **The note is printed.** You are prompted to enter another note or to exit.

```
---------------------------------------------------------------------------
HOOD,ROBIN  603-04-2591P                                    Progress Notes
---------------------------------------------------------------------------
NOTE DATED: 05/31/97 14:58    ADVERSE REACT/ALLERGY
ADMITTED: 05/30/97 10:43 1A
Mr. Hood improving; renewed prescription.

                  Signed by: /es/ JOANN GREEN
                                  JOANN GREEN 05/31/97 14:59
Enter RETURN to continue or '^' to exit:
You may enter another Progress Note. Press RETURN to exit.
Select PATIENT NAME: <Enter>
```

Example 2: Outpatient note

Outpatient notes require more information than inpatient notes, because every outpatient encounter must now be associated with a visit to get workload credit. Most Progress Notes automatically get the visit data from Checkout or a scanned Encounter Form.

Steps to use option:

1. Select *Entry of Progress Note* from your Progress Notes Menu.

2. Type in a patient name.

```
Select Patient(s): doe,WILLIAM C.  09-12-44  243236572    YES    SC
VETERAN
            (1 note )  C: 11/19/96   (addendum 01/28/97 09:55)
                       A: Known allergies

For Patient DOE,WILLIAM C.
```

3. Type in a Progress Note Title. You can use an existing Title or create a new one. If you have created a personal document list through the Personal Preferences' *Document Management* option, that list is displayed here.

```
Personal PROGRESS NOTES Title List for JON GRIN

   1    Crisis Note
   2    Advance Directive
   3    Adverse Reactions
   4    Other Title

TITLE:  (1-4): 3    Adverse React/Allergy
```

4. Since this is a note for an outpatient, you may be prompted to select an existing visit or create a new visit to associate the progress note with.

```
This patient is not currently admitted to the facility...
Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT// <Enter>
The following VISITS are available:
   1>  FEB 24, 1997@09:00                      DIABETES CLINIC
   2>  SEP 05, 1996@10:00                      CARDIOLOGY
CHOOSE 1-2 or <N>EW VISIT
<RETURN> TO CONTINUE
OR '^' TO QUIT: N
Creating new progress note...
          Patient Location:  NUR 1A
        Date/time of Visit:  02/24/97 14:29
         Date/time of Note:  NOW
            Author of Note:  GRIN,JON
   ...OK? YES//<Enter>
SERVICE: MEDICINE// <Enter>    111
```

5. Enter a subject for your note (optional).

```
SUBJECT (OPTIONAL description): ?
   Enter a brief description (3-80 characters) of the contents
   of the document.
SUBJECT (OPTIONAL description): Blue Note
```

6. Type in the text of the note. If it's a SOAP Note or there's a boilerplate for this, you can fill in the blanks or edit existing text. You can use the FileMan text editor or full-screen editor. Sign the Note when you're finished.

```
Calling text editor, please wait...
  1>Follow-up visit to ensure compliance with regimen.
  2><Enter>
EDIT Option: <Enter>
Save changes? YES//<Enter>
Saving General Note with changes...
Enter your Current Signature Code: [HIDDEN CODE]   SIGNATURE VERIFIED..
```

7. Enter the Diagnosis associated with this Progress Note.

☞NOTE: To receive workload credit, VAMCs must now capture Provider, Diagnosis, and Procedure for all outpatient visits.

```
Please Indicate the Diagnoses for which the Patient was Seen:
1       Abdominal Pain
2       Abnormal EKG
3       Abrasion
4       Abscess
5       Adverse Drug Reaction
6       AIDS/ARC
7       Alcoholic, intoxication
8       Alcoholism, Chronic
9       Allergic Reaction
10      Anemia
ANGINA:
11      Stable
12      Unstable
13      Anorexia
14      Appendicitis, Acute
15      Arthralgia
ARTHRITIS
16      Osteo
17      Rheumatoid
18      Ascites
19      ASHD
20      OTHER Diagnosis
Select Diagnoses:  (1-20): 9
```

A list of diagnoses relating to the type of Progress Note is presented for you to choose from.

8. Enter the Procedure associated with this Progress Note.

```
Please Indicate the Procedure(s) Performed:

CARDIOVASCULAR
1       Cardioversion
2       EKG
3       Pericardiocentesis
4       Thoracotomy
MISCELLANEOUS
5       Abscess
6       Less than 2.5 cm
7       2.6 - 7.5 cm
8       Greater than 7.5 cm
9       Burns 1 * Local Treatment
10      Dressings Medium
11      Dressings Small
12      Transfusion
13      Venipuncture
UROLOGY
14      Foley Catheter
ENT
15      Removal Impacted Cerumen
16      Anterior, Simple
17      Anterior, complex
18      Posterior
EYE
19      Foreign Body Removal
20      OTHER Procedure

Select Procedure:  (1-20): 19

You have indicated the following data apply to this visit:

DIAGNOSES:
   995.3    Allergic Reaction  <<< PRIMARY

PROCEDURES:
   65205    Foreign Body Removal

   ...OK? YES// <Enter>

Posting Workload Credit...
```

A list of procedures relating to the type of Progress Note is presented for you to choose from.

8. If you wish, you can print the note now.

```
Print this note? No// y  YES
Do you want WORK copies or CHART copies? CHART// work
DEVICE: HOME// <Enter>  VAX

---------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                          Progress Notes
---------------------------------------------------------------------
NOTE DATED: 02/24/97 08:30    ADVERSE REACT/ALLERGY
VISIT: 02/24/97 08:30 GENERAL MEDICINE
new tests

                  Signed by: /es/ JON GRIN
                                  JON GRIN 02/24/97 08:30

Enter RETURN to continue or '^' to exit:

You may enter another CLINICAL DOCUMENT. Press RETURN to exit.

Select PATIENT NAME: <Enter>
```

Review Progress Notes by Patient

This option lets you review, edit, or sign a selected patient's progress notes.

Steps to use option:

1. Select *Review Progress Notes by Patient* from the Progress Notes menu, then enter the name of the patient.

If the patient has Cautions, Warnings, Allergies, or Directives (CWAD), they are displayed here.

```
Select Progress Notes User Menu Option: 2  Review Progress Notes by
Patient
Select PATIENT NAME: DOE,WILLIAM C.     09-12-44     243236572     YES
SC VETERAN
             (2 notes)  C: 05/28/96 12:37
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies
             (2 notes)  D: 05/28/96 12:36

Available notes:  02/17/95 thru 06/21/96  (31)
```

2. Enter the date range of notes you wish to review.

```
Please specify a date range from which to select notes:
List notes Beginning: 12/01/96  (DEC 01, 1994)
                Thru: 05/01/96// <Enter>  (MAY 01, 1997)
```

3. From the selection displayed, choose the notes you wish to review.

```
1   04/18/97 11:38  Social Work Service              Joe E. Russ, MD
                    Visit: 04/18/97
2   06/21/96 07:47  Lipid Clinic                     Joe E. Russ, MD
                    Visit: 06/18/96
3   06/07/96 00:00  Diabetes Education              Doogey Howser, MD
                    Visit: 04/18/96
4   01/19/96 10:37  SOAP - General Note              Joe E. Russ, MD
                    Visit: 1/10/96
Choose notes:  (1-8): 2
```

4. The note you selected is then displayed.

```
Opening Lipid Clinic record for review...
Browse Document            Jun 26, 1996 10:55:18          Page:  1 of  4
                                    Lipid Clinic
DOE,W C         243-23-6572                    Visit Date: 06/18/96@10:00

DATE OF NOTE: JUN 21, 1996@07:47:47  ENTRY DATE: JUN 21, 1996@07:47:47
      AUTHOR: RUSS,JOE          EXP COSIGNER:
     URGENCY:                        STATUS: COMPLETED

SUBJECTIVE:  5 year old AMERICAN INDIAN OR ALASKA NATIVE MALE here for
             initial evaluation of his DYSLIPIDEMIA.
             COPIED FROM HOOD TO DOE.
PMH:
Significant negative medical history pertinent to the
               evaluation and treatment of DYSLIPIDEMIA:
FH:
+          + Next Screen  - Prev Screen  ?? More actions
     Find                      Make Addendum             Identify Signers
     Print                     Sign/Cosign               Delete
     Edit                      Copy                      Link ...
                                                         Quit
Select Action: Next Screen// <Enter>
```

☞**NOTE:** The screen indicates that this is Page 1 of 4; press Enter after each screen to see all the pages of this note. When reviewing several notes, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

```
Browse Document            Jun 26, 1996 10:56:09          Page:  2 of  4
                                    Lipid Clinic
DOE,W C         243-23-6572                    Visit Date: 04/18/96@10:00
+
SH:
MEDICATION
HISTORY:        CURRENT MEDICATIONS

DIET:           Counseled on AHA Step I diet today by Araceli Neal.
                See her evaluation.

ACTIVITY:
OBJECTIVE:      HT:  70 (08/23/95 11:45)   WT:  207 (08/23/95 11:45)

+          + Next Screen  - Prev Screen  ?? More actions
     Find                      Make Addendum             Identify Signers
     Print                     Sign/Cosign               Delete
     Edit                      Copy                      Link ...
Select Action: Next Screen// <Enter>
```

```
Browse Document          Jun 26, 1996 10:56:43          Page:  3 of  4
Lipid Clinic
DOE,W C         243-23-6572                  Visit Date: 04/18/96@10:00
                TSH/T4: 1.7/1.1

                   FBG: 200           HEMOGLOBIN A1C: 15.2
                 SGOT: 44                URIC ACID: 4.7

ASSESSMENT:     1.      MALE with / without documented CAD
                2.      CV Risk factors:
                3.      Lipid pattern:

PLAN:           1.      Implement recommendations to lower fat intake.
                2.      Repeat FBG and HBG A1C on:
                3.      Return to review lab on:

+          + Next Screen  - Prev Screen  ?? More actions
     Find                    Make Addendum           Identify Signers
     Print                   Sign/Cosign             Delete
     Edit                    Copy                    Link ...
                                                     Quit
Select Action: Next Screen// <Enter>
```

```
Browse Document          Jun 26, 1996 10:57:04       Page:   4 of    4
                                 Lipid Clinic
DOE,W C         243-23-6572                  Visit Date: 04/18/96@10:00
+
/es/ Joe E. Russ, MD
Medical Intern

          + Next Screen  - Prev Screen  ?? More actions
     Find                    Make Addendum           Identify Signers
     Print                   Sign/Cosign             Delete
     Edit                    Copy                    Link ...
                                                     Quit
Select Action: Quit//
```

5. You can then select an action to perform on the note.

```
Select Action: Quit// m   Make Addendum
Adding ADDENDUM
DATE/TIME OF NOTE: 10/25/96@11:21// <Enter>  (OCT 25, 1996@11:21:00)
AUTHOR OF NOTE: GRIN,JON// <Enter>  jg
Calling text editor, please wait...
  1>Should say 55 year old...
  2><Enter>
EDIT Option: <Enter>
Saving Addendum with changes...
Addendum Released.
Enter your Current Signature Code: xxxxxxx (code hidden) SIGNATURE
VERIFIED..

Press RETURN to continue...<Enter>
```

Review Progress Notes

This option lets clinicians get immediately to a patient's list of notes, without preliminary prompts for selection criteria. It's particularly useful for when physicians are seeing patients in clinics and want to pull up their records quickly, as they are able to do with Progress Notes 2.5 (frequently accessed through OE/RR 2.5). Note that the actions below the black bar look more like OE/RR (and CPRS) actions than the ones you'll see in other TIU options.

1. **Select Review Progress Notes from your Progress Notes or OE/RR menu**, whichever one you commonly use. Then enter the name of the patient you are seeing.

```
Select Progress Notes User Menu Option: 2b  Review Progress Notes
Select PATIENT NAME: DOE,WILLIAM C.       09-12-44     243236572     YES
  SC VETERAN
            (2 notes)  C: 02/24/97 08:44
            (1 note )  W: 02/21/97 09:19
                       A: Known allergies
            (2 notes)  D: 03/25/97 08:57
Searching for the progress notes.
```

2. **A screen with a list of notes for your patient is displayed.** Items with the plus symbol (+) have addenda. You can look at details of any of the notes shown (by selecting the Browse or Detailed Display action), create a new note, make an addendum, sign a note, or perform any of the other actions listed below (as well as hidden actions).

```
Progress Notes              May 31, 1997 14:20:10          Page:   1 of   1
<CWAD>                        P R O G R E S S   N O T E S     Last 15 note(s)
DOE,WILLIAM C.       243-23-6572                              SEP 12,1944 (52)
       Title                        Author           Date/Time
1   Adverse React/Allergy           HOWSER,D         05/27/97 00:00     compl
2   Adverse React/Allergy           GREEN,J          05/20/97 17:18     compl
3   CRISIS NOTE                     GREEN,J          05/20/97 17:01     compl
4   Adverse React/Allergy           GREEN,J          05/20/97 11:23     compl
5   GENERAL NOTE                    GREEN,J          05/20/97 11:21     compl
6   CARDIOLOGY NOTE                 GREEN,J          05/20/97 10:56     compl
7   Adverse React/Allergy           RUSS  L,J        04/21/97 16:02     compl
8   Adverse React/Allergy           RUSSETT,J        04/15/97 06:23     compl
9   CARDIOLOGY NOTE                 RUSSETT,J        04/11/97 12:09     compl
10  CRISIS NOTE                     RUSSETT,J        04/11/97 09:09     compl

+ Next Screen      - Prev Screen          ?? More Actions
NW   New Note                SP   Select New Patient    AD   Make Addendum
B    Browse                  SS   Select Search         $    Complete Note(s)
PC   Print Copy              RS   Reset to All Signed   Q    Quit
Select Action: Quit// B   BROWSE
```

3. If you select the action Browse, you can see more details of a note.

```
Select Action: Next Screen// b   Browse
Select Progress Note(s):  (1-15): 1

Reviewing Item #1

Opening Adverse React/Allergy record for review...
```

```
Browse Document              May 31, 1997 14:29:07          Page:  1 of    1
                                  Adverse React/Allergy
DOE,W C         243-23-6572  GENERAL MEDICINE   Visit Date: 04/18/96@10:00
_____________________________________________________________________________

DATE OF NOTE: MAY 27, 1997           ENTRY DATE: MAY 27, 1997@12:15:13
      AUTHOR: HOWSER,DOOGEY        EXP COSIGNER:
     URGENCY:                            STATUS: COMPLETED

Another test...is the antibiotic working?


/es/ Doogey Howser, MD
PGY2 Resident
Signed: 05/27/97 12:21




+ Next Screen  - Prev Screen  ?? More actions
     Find                      Make Addendum             Identify Signers
     Print                     Sign/Cosign               Delete
     Edit                      Copy                      Link ...
                                                         Quit
Select Action: Quit//
```

☞ **NOTE:** When reviewing several notes sequentially, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

4. If you select the action Detailed Display, you can see even more details of a note. Enter DT for Detailed Display. Detailed Display is a "hidden action," an action that appears when you enter two question marks.

```
Select Action: Next Screen// det   Detailed Display
Select Progress Note(s):  (1-15): 1

Reviewing #1
Opening Adverse React/Allergy record for review........
```

```
Detailed Display            May 31, 1997 13:36:09       Page:    1 of    2
                                Adverse React/Allergy
DOE,W C         243-23-6572                        Visit Date: 04/18/96@10:00

  Source Information
   Reference Date: MAY 27, 1997@10:44:19              Author: HOWSER,DOOGEY
       Entry Date: MAY 27, 1997@10:44:19         Entered By: jg
  Expected Signer: GREE,JOE                Expected Cosigner: None
          Urgency: None                      Document Status: COMPLETED
       Line Count: 0                          TIU Document #: 1132
          Subject: None

  Associated Problem     No linked problems.

    Edit Information
        Edit Date: JAN 17, 1997@10:45:08          Edited By: GREE,JOE

  Reassignment History  Document Never Reassigned.

+ Next Screen  - Prev Screen  ?? More actions
     Find                        Print                       Quit
Select Action: Next Screen// <Enter>
```

```
Detailed Display            May 31, 1997 13:37:40       Page:    2 of    2
                                Adverse React/Allergy
DOE,W C         243-23-6572                        Visit Date: 04/18/96@10:00
+
Signature Information
      Signed Date: MAY 27, 1997@10:45:17          Signed By: HOWSER,DOOGEY
                                            Signature Mode: ELECTRONIC
   Cosigned Date: None                         Cosigned By: None
                                          Cosignature Mode: None
Document Body
Mr. Doe's allergies improved with medication.

06/08/97 ADDENDUM:
Improvement was temporary; patient relapsed after a few days.
      EVIN MELD
    + Next Screen  - Prev Screen  ?? More actions
     Find                        Print                       Quit
Select Action: Quit//
```

Review Progress Notes, cont'd

5. If you select the action Select Search, you can narrow your view to a specific context of notes: signed, unsigned, by author, or by a date or date range.

```
Progress Notes                  May 31, 1997 14:20:10     Page:    1 of    1
<CWAD>                       P R O G R E S S   N O T E S     Last 15 note(s)
DOE,WILLIAM C.       243-23-6572                          SEP 12,1944 (52)
     Title                          Author           Date/Time
1    Adverse React/Allergy          HOWSER,D         05/27/97 00:00     compl
2    Adverse React/Allergy          GREEN,J          05/20/97 17:18     compl
3    CRISIS NOTE                    GREEN,J          05/20/97 17:01     compl
4    Adverse React/Allergy          GREEN,J          05/20/97 11:23     compl
5    GENERAL NOTE                   GREEN,J          05/20/97 11:21     compl
6    CARDIOLOGY NOTE                GREEN,J          05/20/97 10:56     compl
7    Adverse React/Allergy          RUSS  L,J        04/21/97 16:02     compl
8    Adverse React/Allergy          RUSSETT,J        04/15/97 06:23     compl
9    CARDIOLOGY NOTE                RUSSETT,J        04/11/97 12:09     compl
10   CRISIS NOTE                    RUSSETT,J        04/11/97 09:09     compl

+ Next Screen  - Prev Screen  ?? More actions
NW   New Note              SP   Select New Patient   AD   Make Addendum
B    Browse                SS   Select Search        $    Complete Note(s)
PC   Print Copy            RS   Reset to All Signed  Q    Quit
Select Action: Quit// ss
  Select Search
```

```
Valid selections are:
  1 - signed notes (all)   2 - unsigned notes       3 - uncosigned notes
  4 - signed notes/author  5 - signed notes/dates

Select context: 1// 2   UNSIGNED NOTES
```

```
Progress Notes          May 31, 1997 14:20:10          Page:    1 of    1
<CWAD>                    P R O G R E S S   N O T E S          1 note(s)
DOE,WILLIAM C.       243-23-6572  1A/A-2                SEP 12,1944 (52)
       Title                          Author          Date/Time
1      Adverse React/Allergy          GREEN,J         05/31/97 15:51   unsig
```

+ Next Screen - Prev Screen ?? More Actions

```
NW   New Note              SP   Select New Patient   AD   Make Addendum
B    Browse                SS   Select Search        $    Complete Note(s)
PC   Print Copy            RS   Reset to All Signed  Q    Quit
Select Action: Quit//
```

All MY UNSIGNED Progress Notes

When you select this option, the program retrieves all your unsigned progress notes for review, edit, or signature.

Steps to use option:

1. Select *All My Unsigned Progress Notes* from the Clinician's Progress Notes Menu.

2. The list is then displayed, from which you can choose any of the listed actions.

```
My UNSIGNED Progress Notes    Oct 25, 1996 11:33:52        Page:  1 of  1
              by AUTHOR (GREEN,JON) or EXPECTED COSIGNER      2 documents
     Patient                Document                      Ref Date    Status
1    DOE,W C    (D6572)  Psychology - Crisis              10/25/96  unsigned
2    DOE,W C    (D6572)  Addendum to Lipid Clinic         10/25/96  unsigned

          + Next Screen  - Prev Screen  ?? More Actions            >>>
     Find                      Sign/Cosign           Change View
     Add Document              Detailed Display      Copy
     Edit                      Browse                Delete Document
     Make Addendum             Print                 Quit
     Link ...                  Identify Signers
Select Action: Quit// s   Sign/Cosign
Select Progress Note(s):  (1-2): 1
Opening Psychology - Crisis record for review...
```

```
SIGN/COSIGN                 Oct 25, 1996 11:34:21              Page:1 of   1
                            Psychology - Crisis
DOE,W C        243-23-6572   2B         Visit Date: 10/25/96@11:32

DATE OF NOTE: OCT 25, 1996@11:32:55 ENTRY DATE: OCT 25, 1996@11:32:55
      AUTHOR: GREEN,JON          EXP COSIGNER:
     URGENCY:                          STATUS: UNSIGNED

Six-month follow-up visit. Patient continues to improve; no change
in treatment required.

          + Next Screen  - Prev Screen  ?? More Actions
     Print                                                    No
Ready for Signature: NO// y   Yes
Item #: 1 Added to signature list.

Enter your Current Signature Code: xxxxxxx (code hidden) SIGNATURE
VERIFIED..
```

Show Progress Notes Across Patients

This option lets you search for and review progress notes by many different criteria: status, type, date range, and cateogory. By different combinations of these criteria, you can see almost any view of your progress notes you could want.

☞ **NOTE:** Use caution in how broad your search is (date range, # of patients, etc.), because searches for a lot of documents can be very system-intensive, slowing down response time for everyone.

Steps to use option:

1. Select *Show Progress Notes Across Patients* from the Clinician's Progress Notes Menu.

2. Select one of the following status(es) of progress notes:

- undictated
- untranscribed
- unreleased
- unverified
- unsigned
- uncosigned
- completed
- amended
- purged
- deleted

3. Select one of the following Progress Note Types.

- Advance Directive
- Adv React/Allergy
- Crisis Note
- Clinical Warning
- Historical Titles

4. Select one or more of the following search categories

- All Categories
- Author
- Expected Cosigner
- Hospital Location
- Patient
- Problem
- Service
- Subject
- Title
- Transcriptionist
- Treating Specialty
- Visit.

5. Select the range of dates to include.

6. The notes meeting the criteria you selected are displayed.

```
UNSIGNED Progress Notes    Jun 18, 1997 09:19:20          Page:  1 of  1
          by AUTHOR from 06/15/96 to 06/18/97              2 documents
     Patient              Document                  Ref Date       Status
1    RUSSELL,D   (R0482) Clinical Warning           06/14/97    unsigned
2    DRAGON,P    (D4029) Crisis Note                06/14/97    unsigned

      + Next Screen  - Prev Screen  ?? More Actions                >>>
     Find                    Sign/Cosign             Change View
     Add Document            Detailed Display        Copy
     Edit                    Browse                  Delete Document
     Make Addendum           Print                   Quit
     Link ...                Identify Signers
Select Action: Quit//
```

Progress Notes Print Options

See Chapter 8 for examples and further descriptions of these options.

Option	Description
Author– Print Progress Notes	This option produces chart or work copies of progress notes for an author for a selected date range.
Location– Print Progress Notes	This option prints chart or work copies of progress notes for all patients who were at a specific location when the notes were written. The patients whose progress notes are printed on this report may not still be at that location. If Chart is selected, each note will start on a new page.
Patient– Print Progress Notes	This option prints or displays progress notes for a selected patient by selected date range.
Ward– Print Progress Notes	This option lets you print progress notes for all patients who are now on a ward for a selected date range. This option is only for ward locations. **NOTE:** This option only prints to a printer, not to your computer screen.

List Notes by Title

This option lets you look up progress notes by title within a specified date range. You can then take any of the usual actions on these notes.

Steps to use option:

1. Select *List Notes by Title* from the Clinician's Progress Notes Menu. Select the titles (one or more) of progress notes to search for.

```
Select Progress Notes User Menu Option: 6  List Notes By Title
Please Select the PROGRESS NOTES TITLES to search for:
  1) ??
Answer with TIU DOCUMENT DEFINITION NAME, or ABBREVIATION, or
     PRINT NAME
 Do you want the entire TIU DOCUMENT DEFINITION List? y  (Yes)
Choose from:
   ADMISSION ASSESSMENT      TITLE
   ADVANCE DIRECTIVE      TITLE
   ADVERSE REACTION/ALLERGY      TITLE
   CLINICAL WARNING      TITLE
   CRISIS NOTE      TITLE
   FINAL DISCHARGE NOTE      TITLE
   GENERAL NOTE      TITLE
   PATIENT EDUCATION      TITLE
Please Select the Progress Notes TITLES to search for:
  1)  ADVERSE REACTION/ALLERGY          TITLE
  2)  CLINICAL WARNING          TITLE
  3) <Enter>
```

2. Enter a beginning and ending date range to choose documents from. The selected documents are displayed.

```
Start Reference Date [Time]: T-2// t-10  (MAR 01, 1997)
Ending Reference Date [Time]: NOW// <Enter>  (MAR 11, 1997@09:10)
Searching for the documents.........
Progress Notes by Title  Mar 11, 1997 09:10:09     Page:    1 of    1
                        from 03/01/97 to 03/11/97              8 documents
     Patient              Document                  Ref Date  Status
1    HOOD,R     (H2591) Adverse React/Allergy     03/05/97  unsigned
2    DOE,W C    (D6572) Adverse React/Allergy     03/05/97  completed
3    RAMBO,J    (R1239) CLINICAL WARNING          03/05/97  completed
4    HOOD,R     (H2591) Adverse React/Allergy     03/11/97  completed

+ Next Screen  - Prev Screen  ?? More Actions                  >>>
  Find              Sign/Cosign          Change View
  Add Document      Detailed Display     Copy
  Edit              Browse               Delete Document
  Make Addendum     Print                Quit
  Link ...          Identify Signers
Select Action: Quit//
```

3. You may now choose an action such as Edit, Sign/Cosign, Make Addendum or Detailed Display.

```
Progress Notes by Title  Mar 11, 1997 09:10:09     Page:    1 of    1
                        from 03/01/97 to 03/11/97              8 documents
     Patient              Document                    Ref Date  Status
1    HOOD,R     (H2591)  Adverse React/Allergy       03/05/97  unsigned
2    DOE,W C    (D6572)  Adverse React/Allergy       03/05/97  completed
3    RAMBO,J    (R1239)  CLINICAL WARNING            03/05/97  completed
4    HOOD,R     (H2591)  Adverse React/Allergy       03/11/97  completed
5    HOOD,R     (H2591)  Adverse React/Allergy       03/10/97  completed
6    SMITH,S    (S1462)  CLINICAL WARNING            03/04/97  uncosigned
7    PUBLIC,J   (P4365)  Adverse React/Allergy       03/04/97  completed
8    NEW,P      (N1234)  Adverse React/Allergy       03/06/97  completed

+ Next Screen  - Prev Screen  ?? More Actions                  >>>
  Find              Sign/Cosign          Change View
  Add Document      Detailed Display     Copy
  Edit              Browse               Delete Document
  Make Addendum     Print                Quit
  Link ...          Identify Signers
Select Action: Quit//   DET=3
```

4. A detailed display of the note you chose appears on your screen.

```
Detailed Display          Mar 11, 1997 09:21:40       Page: 1 of    2
                              CLINICAL WARNING
RAMBO,J        555-12-1239                  Visit Date: 02/04/97@13:00

 Source Information
  Reference Date: MAR 05, 1997@14:50:17            Author: PRIE,DOBIE
      Entry Date: MAR 05, 1997@14:50:18        Entered By: DP
 Expected Signer: PRIE,DOBIE          Expected Cosigner: None
         Urgency: None                    Document Status: COMPLETED
      Line Count: 0
         Subject: None

 Associated Problems   No linked problems.

  Edit Information
       Edit Date: MAR 05, 1997@14:50:41       Edited By: PRICE,DEBBIE

  Signature Information
+         + Next Screen  - Prev Screen  ?? More actions
     Find                        Print                       Quit
Select Action: Next Screen//
```

Search by Patient AND Title

This option lets you search for and review progress notes by patient, as well as many other criteria: status, type, date range, and category. You can then take any of the usual actions on these notes.

Steps to use option:

1. Select the *Search by Patient AND Title* option from the Progress Notes User Menu.

2. Select a Patient.

```
Select Progress Notes User Menu Option: Search by Patient AND Title
Select PATIENT NAME: doe,WILLIAM C.  09-12-44  243236572     YES     SC
VETERAN
             (1 note )  C: 07/22/91 11:27
             (1 note )  W: 07/22/91 11:34
                        A: Known allergies
             (1 note )  D: 04/01/92 10:58
```

If the patient has Cautions, Warnings, Allergies, or Directives (CWAD), they are displayed here.

3. Type in one or more Progress Note Titles to search for.

```
Please Select the PROGRESS NOTE TITLES to search for:
  1)  Lipid CLINIC          TITLE
  2)  Diabetes EDUCATION          TITLE
  3) <Enter>

 Start Reference Date [Time]: T-2// <Enter> (SEP 10, 1996
Ending Reference Date [Time]: NOW//<Enter>  (SEP 12, 1996@11:06)
Searching for the documents...
```

4. A list is displayed of all notes that meet the criteria you specified.

```
ALL Progress Notes      Sep 12, 1996 11:06:24          Page:    1 of    1
                    by PATIENT from 07/14/96 to 09/12/96       2 documents
     Patient               Document                    Ref Date     Status
1    DOE,W C    (D6572)   Diabetes Education          09/12/96   completed
2    DOE,W C    (D6572)   Addendum to Diabetes Edu    09/09/96   unsigned

        + Next Screen  - Prev Screen  ?? More Actions            >>>
  Find              Sign/Cosign          Change View
  Add Document      Detailed Display     Copy
  Edit              Browse               Delete Document
  Make Addendum     Print                Quit
  Link ...          Identify Signers
Select Action: Quit// <Enter>
```

Progress Notes Statuses and Actions

Statuses

Status	Description
amended	The document has been completed and a privacy act issue has required its amendment.
completed	The document has acquired all necessary signatures and is legally authenticated.
deleted	This status applies to documents which have been deleted per the Privacy Act, leaving the audit trail information intact, while deleting the body of the document and its addenda.
purged	The grace period for purge has expired and the report text has been removed from the online record to recover disk space. NOTE: only completed documents may be purged. It is assumed that the chart copy of the document has been retained for archival purposes.
uncosigned	The document is complete with the exception of cosignature (e.g., by a supervisor).
undictated	The document is required and a record has been created in anticipation of dictation and transcription, but the system has not yet been informed of its dictation.
unreleased	The document is in the process of being entered into the system, but has not yet been released by the originator (i.e., the person who entered the text directly online).
unsigned	The document is online in a draft state, but the author hasn't signed.
untranscribed	The document is required and the system has been informed of its dictation, but the transcription hasn't been entered or received by upload.
unverified	The document has been released or uploaded, but must be verified before the document may be displayed.

☞ **NOTE:**

\+ = a report has addenda.

***** = priority (STAT) document.

Progress Note Actions

```
Find                    Sign/Cosign             Change View
Add Document            Detailed Display        Copy
Edit                    Browse                  Delete Document
Make Addendum           Print                   Quit
Link ...                Identify Signers
```

The following actions are also available (enter ?? to see these):

```
+     Next screen       UP   Up a Line          ADPL Auto Display(On/Off)
-     Previous Screen   DN   Down a Line        Q    Quit
FS    First Screen      GO   Go to Page         CT   Change Title
LS    Last Screen       RD   Re Display Screen  CWAD CWAD Display
```

Action	Description
Find	Allows you to search a list of documents for a text string (word or partial word) from the current position to the end of the list.
Add Document	**Lets you add a new Progress Note.**
New Note	Same as Add Document, used in CPRS contexts.
Edit	Allows authorized users to edit selected documents online.
Make Addendum	Allows authorized users to add addenda to selected documents online. Physicians will be prompted for their signatures upon exit.
Link	Allows you to link documents to either problems, visits, or other documents. Such associations permit a variety of clinically useful "views" of the online record.
Sign/Cosign	Allows clinicians to electronically sign selected discharge summaries or addenda. NOTE: Electronic signature carries the same legal ramifications that wet signature of a hard-copy discharge summary carries. You are advised to carefully review each discharge summary for content and accuracy before exercising this option.
Detailed Display	Displays the report type, patient, urgency, line count, author, attending physician, transcriptionist, and verifying clerk, and also admission, discharge, dictation, transcription, signature, and amendment dates.
Browse	Lets you browse through Documents from the Review Screen, by scrolling sequentially through the selected documents and their addenda. You can search for a word or phrase, or print draft copies.
Print	Allows you to print copies of VAF 10-1000 for selected summaries.
Identify Signers	Allows authorized users to identify additional signers for a document.
Change View	Lets you change the displayed reports to signature status, review screen, or dictation date range.
Copy	Allows authorized users to copy one or more documents to other patients and encounters. This is particularly useful when documenting group sessions, etc.
Delete Document	Allows authorized users to delete a discharge summary at the patient's request, per the Privacy Act.
Change Title	This action on the "hidden" list lets you change a Title for a Progress Note (e.g., CWAD Notes) to another Title.
Quit	Lets you quit the current menu level.

Interdisciplinary Notes

Interdisciplinary Notes are a new feature of Text Integration Utilities (TIU) for expressing notes from different care givers as a single episode of care. They always start with a single note by the initial contact person (e.g., triage nurse, attending) and continue with separate notes created and signed by other providers and attached to the original note.

To accomplish this, your facility must:

1. Set up note titles for the initiating note and the attachment notes—also called parent note and child notes.
2. Use version 15 of the CPRS Windows (GUI) interface or later.

The *Text Integration Utilities (TIU) Implementation Guide* contains a new appendix, Appendix C, that describes in detail the technical aspects of setting up Interdisciplinary Notes.

The rest of this section shows the actions Interdisciplinary Notes using Version 15 of the CPRS Windows interface.

The Parent Note

You start any interdisciplinary note with a parent note. A parent is a note title that includes an ASU (Authorization/Subscription Utility) rule allowing attachments. Your facility should have set up these titles with unique names that allow you to easily identify them.

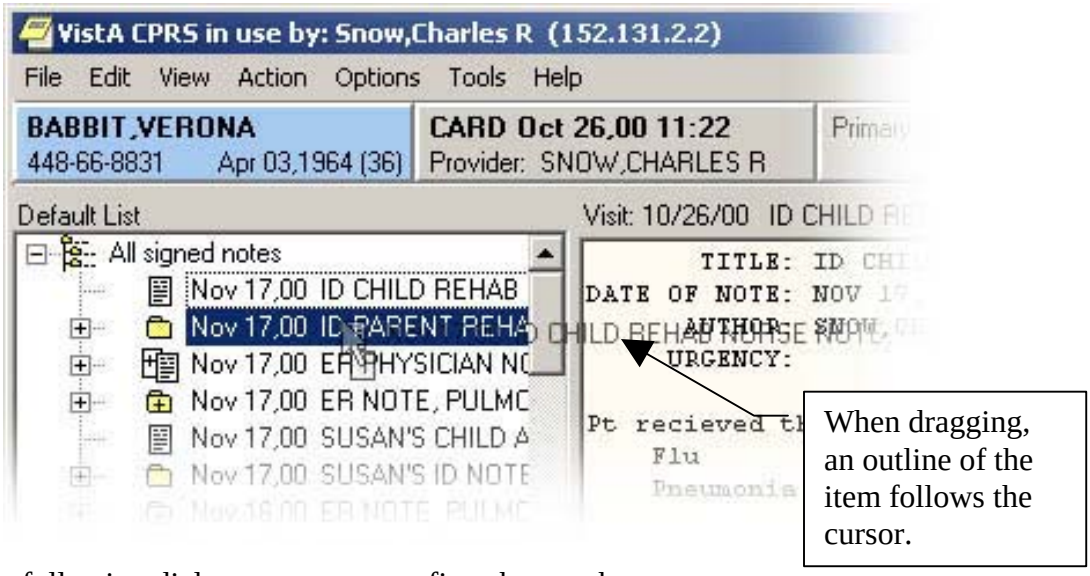
Only certain members of your team should start Interdisciplinary Notes. To establish a parent note for a patient and a specific episode of care, all they do is create a note with the proper title, and sign it.

The Child Note(s)

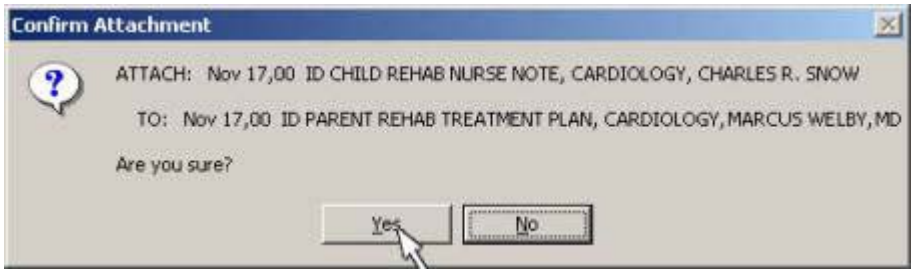
Continue an interdisciplinary note by attaching one or more child notes to the parent note. The intention is for each child note to be by a different provider involved in this episode of care. Again your facility has established a number of notes with unique titles to act as child notes.

Previously created note attachments are made to the parent node by dragging and dropping. (Dragging and dropping may be a new concept to you. To drag and drop:

1. Point the cursor at the child note.
2. Hold down the left mouse button.
3. Move the cursor over the parent note. A ghost of the child note title will follow the cursor.
4. Release the left mouse button.



The following dialog appears to confirm the attachment:

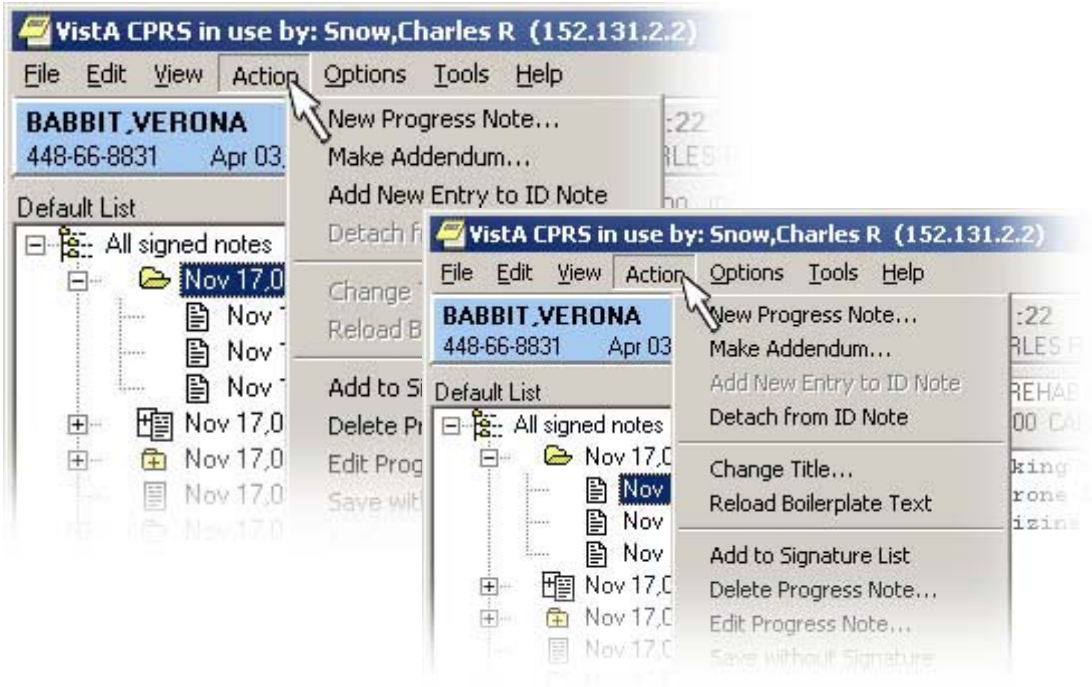


Menu Actions

There are two Interdisciplinary Note specific menu commands in the CPRS Windows interface. They are:

- Add New Entry to ID Note
- Detach from ID Note

These commands become active (usable) when the correct kind of note is selected as in these illustrations:



In the first case, the parent note has been selected. In this case, you can add a new note to the Interdisciplinary Note without having to later attach it (via drag and drop).

In the second case, one of the child notes has been selected. In this case, you can detach this note from the parent.

The Display

CPRS displays all notes in the Interdisciplinary Note reference date order unless one of the child notes is selected. In this case, CPRS displays the child note, then it displays all the notes in the Interdisciplinary Note reference date order; repeating the current note. In all other respects, the format of the display is the same as a regular note.

The display of unsigned notes depends upon the business rules in effect at your site. These rules may allow you to view the unsigned child notes of other providers in the context of an Interdisciplinary Note. This is up to your local authorities.

Meaning of Icons

In the CPRS Windows interface, notes are listed in a tree-structured arrangement. This is intended to graphically show a number of things:

1. Signed and Unsigned notes.
2. Notes with an addendum attached.
3. Interdisciplinary notes.
4. Regular notes.

The meaning of the various icons is:

Icon	Meaning
	A list of notes, either signed or unsigned.
	An Interdisciplinary Note. The open folder indicates that all the children are listed.
	A child to an Interdisciplinary Note.
	A regular note, or a child note that has not yet been attached to a parent.
	The plus sign indicates an addendum is present.
	An addendum

In the List Manager interface, similar devices are used to indicate the type of note:

Symbol	Meaning
(Nothing)	A regular note, or a child note that has not yet been attached to a parent.
<	An Interdisciplinary Note parent.
>	An Interdisciplinary Note child.
+	An addendum is present.
+<	An Interdisciplinary Note with one or more addendum present. The addenda may be in the child note(s).
+>	An Interdisciplinary Note child with one or more addendum present.

LM Considerations

CPRS

Interdisciplinary Notes are not supported in the List Manager (LM) interface of CPRS with the following exception: Interdisciplinary Notes are viewed and printed just as other notes supported by TIU.

TIU

To access the full range of Interdisciplinary Notes features, use the **Progress Note User Menu** and choose exported option **2b, Review Progress Notes.**

The IN (Interdiscipl'ry Note) action is the universal action for operations on Interdisicplinary Notes. You should select a note before selecting this menu option. If the note selected is a parent note, it will prompt you to enter a child of this note. If the note selected is an unattached child note, it will prompt you to select the parent that goes with it.

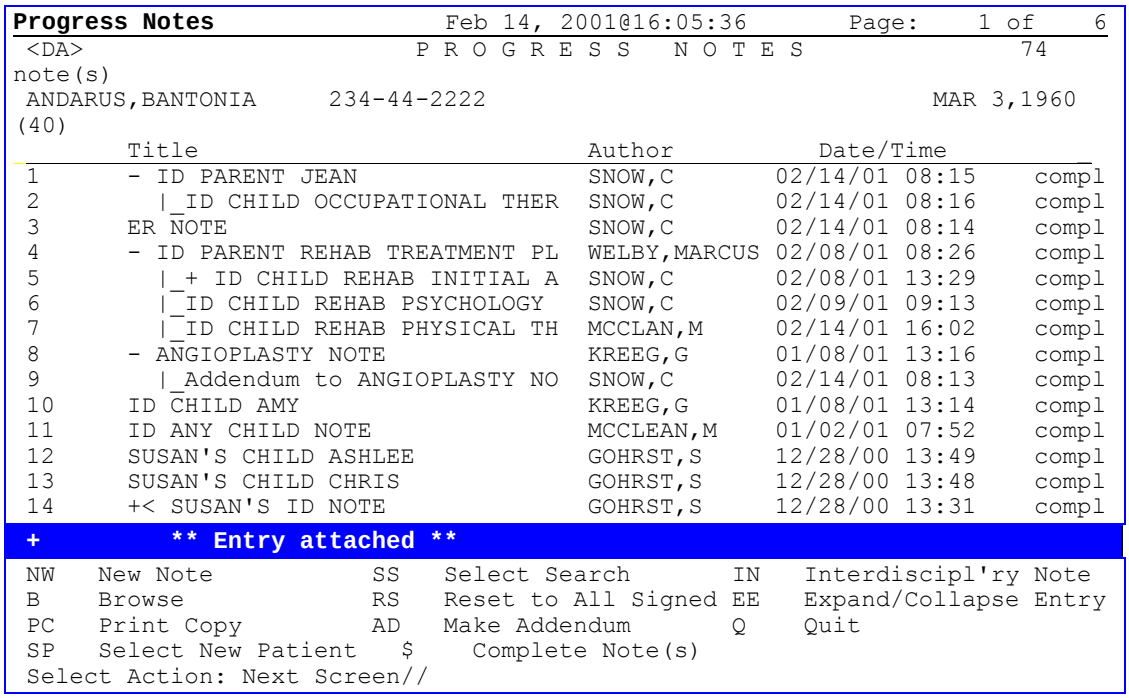
In this example, a new child note is added to an existing parent note:

```
Progress Notes                  Feb 14, 2001@15:09:32       Page:    1 of    6
 <DA>                        P R O G R E S S   N O T E S                 74
note(s)
 ANDARUS,BANTONIA     234-44-2222                                MAR 3,1960 (40)
        Title                                Author       Date/Time
 1      - ID PARENT JEAN                     SNOW,C       02/14/01 08:15    compl
 2        |_ID CHILD OCCUPATIONAL THER       SNOW,C       02/14/01 08:16    compl
 3      ER NOTE                              SNOW,C       02/14/01 08:14    compl
 4      - ID PARENT REHAB TREATMENT PL       WELBY,MARCUS 02/08/01 08:26    compl
 5        |_- ID CHILD REHAB INITIAL A       SNOW,C       02/08/01 13:29    compl
 6        |   |_Addendum to ID CHILD R       SNOW,C       02/14/01 08:11    compl
 7        |_ID CHILD REHAB PSYCHOLOGY        SNOW,C       02/09/01 09:13    compl
 8      - ANGIOPLASTY NOTE                   KREEG,G      01/08/01 13:16    compl
 9        |_Addendum to ANGIOPLASTY NO       SNOW,C       02/14/01 08:13    compl
 10     ID CHILD AMY                         KREEG,G      01/08/01 13:14    compl
 11     ID ANY CHILD NOTE                    MCCLEAN,M    01/02/01 07:52    compl
 12     SUSAN'S CHILD ASHLEE                 GORST,S      12/28/00 13:49    compl
 13     SUSAN'S CHILD CHRIS                  GORST,S      12/28/00 13:48    compl
 14     +< SUSAN'S ID NOTE                   GORST,S      12/28/00 13:31    compl
 +         + Next Screen  - Prev Screen  ?? More Actions
 NW   New Note            SS   Select Search       IN   Interdiscipl'ry Note
 B    Browse              RS   Reset to All Signed EE   Expand/Collapse Entry
 PC   Print Copy          AD   Make Addendum       Q    Quit
 SP   Select New Patient   $    Complete Note(s)
 Select Action: Next Screen// IN
```

```
To ADD a new entry to an interdisciplinary note, please select the
 interdisciplinary note.
   To ATTACH an existing stand-alone note to an interdisciplinary note,
 please select the note you want to attach.
 Select Progress Note:  (1-14): 4
Are you adding a new interdisciplinary entry to this note? YES// <Enter>
Adding a new interdisciplinary entry to
 ID PARENT REHAB TREATMENT PLAN
  Please select a title for your entry:
 TITLE: ??
 Choose from:
    ER NURSE NOTE        TITLE
    ER PHYSICIAN NOTE        TITLE
    OCCUPATIONAL THERAPY CHILD NOTE        TITLE
    REHAB CHILD DISCHARGE PLANNING NOTE        TITLE
    REHAB CHILD INITIAL ASSESSMENT NOTE        TITLE
    REHAB CHILD NURSE NOTE        TITLE
    REHAB CHILD PHARMACY NOTE        TITLE
    REHAB CHILD PHYSICAL THERAPY NOTE        TITLE
    REHAB CHILD PSYCHOLOGY NOTE        TITLE
                  ^
 TITLE: REHAB CHILD PHYSICAL THERAPY NOTE       TITLE
  Enter/Edit PROGRESS NOTE...
           Patient Location:  PULMONARY CLINIC
         Date/time of Visit:  02/08/01 08:26
          Date/time of Note:  NOW
             Author of Note:  MCCLENAHAN,MARGY
...OK? YES// <Enter>
Calling text editor, please wait...
   1>The Pt is doing very well ...
   2>
 EDIT Option: <Enter>

 Saving ID CHILD REHAB PHYSICAL THERAPY NOTE with changes...

Enter your Current Signature Code: ********
```


Progress Notes Feb 14, 2001@16:05:36 Page: 1 of 6
<DA> P R O G R E S S N O T E S 74
note(s)
ANDARUS,BANTONIA 234-44-2222 MAR 3,1960
(40)
Title Author Date/Time
1 - ID PARENT JEAN SNOW,C 02/14/01 08:15 compl
2 |_ID CHILD OCCUPATIONAL THER SNOW,C 02/14/01 08:16 compl
3 ER NOTE SNOW,C 02/14/01 08:14 compl
4 - ID PARENT REHAB TREATMENT PL WELBY,MARCUS 02/08/01 08:26 compl
5 |_+ ID CHILD REHAB INITIAL A SNOW,C 02/08/01 13:29 compl
6 |_ID CHILD REHAB PSYCHOLOGY SNOW,C 02/09/01 09:13 compl
7 |_ID CHILD REHAB PHYSICAL TH MCCLAN,M 02/14/01 16:02 compl
8 - ANGIOPLASTY NOTE KREEG,G 01/08/01 13:16 compl
9 |_Addendum to ANGIOPLASTY NO SNOW,C 02/14/01 08:13 compl
10 ID CHILD AMY KREEG,G 01/08/01 13:14 compl
11 ID ANY CHILD NOTE MCCLEAN,M 01/02/01 07:52 compl
12 SUSAN'S CHILD ASHLEE GOHRST,S 12/28/00 13:49 compl
13 SUSAN'S CHILD CHRIS GOHRST,S 12/28/00 13:48 compl
14 +< SUSAN'S ID NOTE GOHRST,S 12/28/00 13:31 compl
+ ** Entry attached **
NW New Note SS Select Search IN Interdiscipl'ry Note
B Browse RS Reset to All Signed EE Expand/Collapse Entry
PC Print Copy AD Make Addendum Q Quit
SP Select New Patient $ Complete Note(s)
Select Action: Next Screen//

Discharge Summary

Clinicians can review, enter, print, and sign discharge summaries, either by individual patient or by multiple patients.

Clinician's Discharge Summary Menu

Option	Description
Individual Patient Discharge Summary	This option lets you review, edit, or sign a patient's discharge summaries.
All MY UNSIGNED Discharge Summaries	This option shows you all unsigned discharge summaries for you to review, edit, or sign. You must have signing or cosigning privileges to sign or cosign, based on your document definition, user class status, and business rules governing these actions. See your Clinical Coordinator if you have any problems or questions.
Multiple Patient Discharge Summaries	This option shows you discharge summaries for selected statuses, types, and categories, which you can then review, edit, and/or sign.

Individual Patient Discharge Summary

This option lets you review, edit, or sign a patient's discharge summaries.

Steps to use option:

1. Select *Individual Patient Discharge Summary* from your TIU menu, then select a patient.

If the patient has any CWAD (Crisis, Warning, Allergies, and Directives) notes, they are displayed here.

```
Select Discharge Summary User Menu Option:  Individual Patient Discharge
Summary
Select PATIENT NAME: DOE,WILLIAM C.09-12-44   243236572   YES SC VETERAN
             (2 notes)  C: 05/28/96 12:37
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies

Available summaries:  02/12/96 thru 02/12/96  (1)
```

2. Enter a date range to select summaries from, then select a summary from the ones displayed. The selected summary is displayed. Then select an action.

```
Browse Document              Jun 26, 1996 14:21:22      Page:    1 of    7
                                  Discharge Summary
DOE,W C         243-23-6572    1A              Adm: 07/22/91  Dis: 02/12/96
   DICT DATE: JUN 09, 1996              ENTRY DATE: JUN 12, 1996@15:07:22
 DICTATED BY: HOWSER,DOOGEY              ATTENDING: RUELL,JOE
     URGENCY: priority                       STATUS: UNSIGNED

DIAGNOSIS:
1.  Status post head trauma with brain contusion.
2.  Status post cerebrovascular accident.
3.  Coronary artery disease.
4.  Hypertension.
+          + Next Screen  - Prev Screen  ?? More actions
    Find                       Make Addendum             Identify Signers
    Print                      Sign/Cosign               Delete
    Edit                       Copy                      Link ...
                                                         Quit
Select Action: Quit// p   Print
DEVICE: HOME//<Enter>  VAX
```

Printed Discharge Summary Example

```
SALT LAKE CITY   priority                          06/26/96 14:24       Page:  1
-------------------------------------------------------------------------------
PATIENT NAME                    | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
DOE,WILLIAM C.                  |  51 |  M  | MEXI | 243-23-6572 |
-------------------------------------------------------------------------------
  ADM DATE   |  DISC DATE   | TYPE OF RELEASE   | INP | ABS | WARD NO
JUL 22, 1991 | FEB 12, 1996 | REGULAR           |1666 |   0 | 1A
-------------------------------------------------------------------------------
DICTATION DATE: JUN 09, 1996            TRANSCRIPTION DATE: JUN 12, 1996
TRANSCRIPTIONIST: bs

DIAGNOSIS:
1.  Status post head trauma with brain contusion.
2.  Status post cerebrovascular accident.
3.  End stage renal disease on hemodialysis.
4.  Coronary artery disease.
5.  Congestive heart failure.
6.  Hypertension.
7.  Non insulin dependent diabetes mellitus.
8.  Peripheral vascular disease, status post thrombectomies.
9.  Diabetic retinopathy.

OPERATIONS/PROCEDURES:
1. MRI.
2. CT SCAN OF HEAD.

HISTORY OF PRESENT ILLNESS:
Patient is a 49-year-old, white male with past medical history of end stage
renal disease, peripheral vascular disease, status post BKA, coronary artery
disease, hypertension, non insulin dependent diabetes mellitus, diabetic
retinopathy, congestive heart failure, status post CVA, status post
thrombectomy admitted from Anytown VA after a fall from his wheelchair in the
hospital.  He had questionable short-lasting loss of consciousness but patient
is not very sure what has happened.  He denies headache, vomiting, vertigo.
                                                                    D R A F T
Press RETURN to continue or '^' to exit:

SALT LAKE CITY   priority                          06/26/96 14:24       Page:  2
-------------------------------------------------------------------------------
PATIENT NAME                    | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
DOE,WILLIAM C.                  |  51 |  M  | MEXI | 243-23-6572 |
-------------------------------------------------------------------------------
On admission patient had CT scan which showed a small area of parenchymal
hemorrhage in the right temporal lobe which is most likely consistent with
hemorrhagic contusion without mid line shift or incoordination.

ACTIVE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Coumadin 2.5 mgs p.o. qd,
ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15
ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d. with food, Betoptic
0.5% ophthalmologic solution gtt OU b.i.d., Nephrocaps 1 tablet p.o. qd,
Pilocarpine 4% solution 1 gtt OU b.i.d., Compazine 10 mgs p.o. t.i.d. prn
nausea, Tylenol 650 mgs p.o. q4 hours prn.

Patient is on hemodialysis, no known drug allergies.
```

Printed Discharge Summary Example cont'd

PHYSICAL EXAMINATION: Patient had stable vital signs, his blood pressure was 160/85, pulse 84, respiratory rate 20, temperature 98 degrees. Patient was alert, oriented times three, cooperative. His speech was fluent, understanding of spoken language was good. Attention span was good. He had moderate memory impairment, no apraxia noted. Cranial nerves patient was blind, pupils are not reactive to light, face was asymmetric, tongue and palate are mid line. Motor examination showed muscle tone and bulk without significant changes. Muscle strength in upper extremities 5/5 bilaterally, sensory examination revealed intact light touch, pinprick and vibratory sensation. Reflexes 1+ in upper extremities, coordination finger to nose test within normal limits bilaterally. Alternating movements without significant changes bilaterally. Neck was supple.

LABORATORY: Showed sodium level 135, potassium 4.6, chloride 96, CO2 26, BUN 39, creatinine 5.3, glucose level 138. White blood cell count was 7, hemoglobin 11, hematocrit 34, platelet count 77.

HOSPITAL COURSE: Patient was admitted after head trauma with multiple medical problems. His coumadin was held. Patient had cervical spine x-rays which showed definite narrowing of C5, C6 interspace, slight retrolisthesis at this level, prominent spurs at this level as well as above and below. CT scan on admission showed a moderate amount of scalp thinning with subcutaneous air overlying the left frontal lobe. The basal cisterns are patent and there is no mid line shift or uncal herniation. Patient has also a remote left posterior border zone infarct with hydrocephalus ex vaccuo of the left occipital horn, a rather large remote infarct in the inferior portion of the left cerebellar hemisphere. He had hemodialysis q.o.d. He restarted treatment with Coumadin. His last PT was 11.9, PTT 31. Patient refused before hemodialysis new blood tests. His condition remained stable.

DISCHARGE MEDICATIONS: Isordil 20 mgs p.o. t.i.d., Ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Betoptic 0.5% OU b.i.d., Nephrocaps 1 p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Coumadin 2.5 mgs p.o. qd, Tylenol 650 mgs p.o. q6 hours prn pain.

DISPOSITION/FOLLOW-UP:
Recommend follow PT/PTT. Patient is on coumadin and CBC with differential because patient has chronic anemia and thrombocytopenia.

Patient will be transferred to Anytown VA in stable condition on 5/19/96.

WORK COPY ========== UNOFFICIAL - NOT FOR MEDICAL RECORD ========== DO NOT FILE
SIGNATURE PHYSICIAN/DENTIST SIGNATURE APPROVING PHYSICIAN/DENTIST

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========== CONFIDENTIAL INFORMATION ==========

All MY UNSIGNED Discharge Summaries

This option shows you all unsigned discharge summaries for you to review, edit, or sign. You must have signing or cosigning privileges to sign or cosign, based on your document definition, user class status, and business rules governing these actions. See your Clinical Coordinator if you have any problems or questions about electronic signature or cosigning..

Steps to use option:

1. Select *All MY UNSIGNED Discharge Summaries* from your TIU menu.

2. Your unsigned discharge summaries are displayed.

```
Discharge Summaries       Jun 18, 1996 10:13:45    Page: 1 of   1
    by AUTHOR (GREE,JON) or EXPECTED COSIGNER  0 documents
     Patient           Document                 Ref Date    Status
-------------------------------------------------------------------

2 AARON,B (A4831)      Discharge Summary        03/15/96   uncosig




      + Next Screen  - Prev Screen  ?? More Actions        >>>
     Find                 Sign/Cosign              Change View
     Add Document         Detailed Display         Copy
     Edit                 Browse                   Delete Document
     Make Addendum        Print                    Quit
     Link ...             Identify Signers
Select Action: Quit// COSIGN
```

3. Select an action such as Sign/Cosign if you are authorized to perform these.

☞ **NOTE:** You can enter **C**osign rather than **S**ign/Cosign if you want to cosign.

Multiple Patient Discharge Summaries

This option shows you discharge summaries for selected statuses, types, and categories, which you can then review, edit, and/or sign.

☞**Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone.

Steps to use option:

1. Select Multiple Patient Discharge Summaries from your TIU menu.

2. Select one or more of the following statuses:

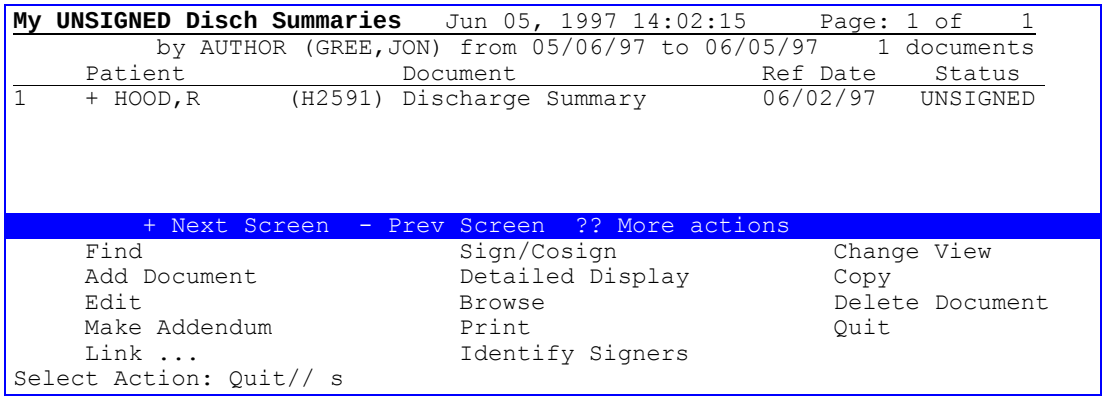
- untranscribed
- unreleased
- unverified
- unsigned
- uncosigned
- completed
- amended
- purged
- deleted

3. Select one of the following search categories:

- All Categories
- Patient
- Title
- Author
- Problem
- Transcriptionist
- Expected Cosigner
- Service
- Treating Specialty
- Hospital Location
- Subject
- Visit.

4. Enter a date range.

5. A list is displayed of the summaries that meet your specifications.



6. You can now take an appropriate action on one or all of the summaries.

Discharge Summary Statuses and Actions

Statuses

Status	Description
amended	The document has been completed and a privacy act issue has required its amendment.
completed	The document has acquired all necessary signatures and is legally authenticated.
deleted	This status applies to documents which have been deleted per the Privacy Act, leaving the audit trail information intact while deleting the body of the document and its addenda.
purged	The grace period for purge has expired and the report text has been removed from the online record to recover disk space. NOTE: only completed documents may be purged. It is assumed that the chart copy of the document has been retained for archival purposes.
uncosigned	The document is complete with the exception of cosignature (i.e., by the supervisor).
undictated	The document is required and a record has been created in anticipation of dictation and transcription but the system has not yet been informed of its dictation.
unreleased	The document is in the process of being entered into the system but has not yet been released by the originator (i.e., the person who entered the text directly online).
unsigned	The document is online in a draft state but the author hasn't signed.
untranscribed	The document is required and the system has been informed of its dictation but the transcription hasn't been entered or received by upload.
unverified	The document has been released or uploaded but must be verified before the document may be displayed.

Actions

```
Find                    Sign/Cosign             Change View
Add Document            Detailed Display        Copy
Edit                    Browse                  Delete Document
Make Addendum           Print                   Quit
Link ...                Identify Signers
```

Actions	Description
Add Document	Enter a new Document.
Change View	Allows you to modify the list of reports by signature status, review screen, and dictation date range without exiting the review screen.
Copy	Allows authorized users to duplicate the current document. This is especially useful when composing a note for a group of patients (e.g., therapy group) and rapid duplication to all members of the group is appropriate.
Delete Document	Allows authorized users to delete a discharge summary at the patient's request, per the Privacy Act.
Detailed Display	Displays the report type, patient, urgency, line count, author, attending physician, transcriptionist, and verifying clerk, in addition to the admission, discharge, dictation, transcription, signature and amendment dates, without showing the narrative report text.
Edit	Allows authorized users to edit the current document online. When electronic signature is enabled, physicians will be prompted for their signatures upon exit, thereby allowing doctors to review, edit, and sign as a one-step process.
Find	Allows you to search for a text string (word or partial word) from the current position in the summary through its end. Upon reaching the end of the document, you will be asked whether to continue the search from the beginning of the document through the origin of the search.
Identify Signers	Allows authorized users to identify additional users who are to be alerted for concurrence signature. These signers may enter an addendum if they do not concur with the content of the document, but they may not edit the document itself.
Link	Allows you to link documents to either problems, visits, or other documents. Such associations permit a variety of clinically useful "views" of the online record.
Make Addendum	Allows authorized users to add an addendum to the current document online. When electronic signature is enabled, physicians are prompted for their signatures upon exit, thereby allowing doctors to review, edit and sign as a one-step process.
Print	Allows you to print copies of selected documents on your corresponding VA Standard Forms to a specified device.
Quit	Allows you to quit the current menu level.
Sign/Cosign	Allows clinicians to electronically sign the current summary. NOTE: Electronic signature carries the same legal ramifications that wet signature of a hard-copy discharge summary carries. Carefully review each discharge summary for content and accuracy before exercising this option.

Integrated Document Management

The options on this menu allow clinicians to review, edit, or sign progress notes, discharge summaries, and any other documents set up at your site. This menu is especially useful for clinicians who wish to see an integrated view of documents, to be able to edit or sign many types in one session without changing applications.

Option Name	Description
Individual Patient Document	Allows you to interactively review, edit, or sign a designated clinical document for a designated patient.
All MY UNSIGNED Documents	Gets all unsigned documents for review, edit, and signature.
Multiple Patient Documents	Provides an integrated Review Screen of all TIU documents.
Enter/edit Document	Allows you to enter and edit clinical documents directly online.

Individual Patient Document

Use this option to review an individual document for a patient. You can then edit, sign, delete, or perform other actions, as appropriate, on the document.

Steps to use option:

1. Select *Individual Patient Document* from your Integrated Document Management menu on your TIU menu.

2. Select a patient.

3. Enter a date range to display documents for. A list is displayed of that patient's documents for the specified time period.

```
Please specify a date range from which to select documents:
List documents Beginning: 02/17/92// 1/96  (JAN 1996)
                     Thru: 06/07/96// <Enter>  (JUN 07, 1996)

1  06/07/96 00:00  Diabetes Education        Doogey Howser, MD
                    Visit: 04/18/96
2  06/05/96 17:23  Lipid Clinic             Joe E. Russ,
                    Visit: 04/18/96
3  06/05/96 11:10  Addendum to Lipid Clinic  Joe E. Russ,
                    Visit: 04/24/96
4  05/28/96 12:37  Crisis Note               STEVEN B. WINTER
                    Visit: 02/20/96
5  05/28/96 12:37  Crisis Note               STEVEN B. WINTER
                    Visit: 02/20/96
```

4. Choose a document from the list.

```
Choose documents:  (1-6): 1

Opening Diabetes Education record for review...
```

Individual Patient Document cont'd

```
Browse Document          Jun 26, 1996 17:08:45      Page: 1 of   1
                        Diabetes Education
DOE,W C        243-23-6572              Visit Date: 07/22/91@11:06

DATE OF NOTE: JAN 09, 1996@17:51:04  ENTRY DATE: JAN 09,
1996@17:51:04
      AUTHOR: DENT,STUART          EXP COSIGNER: RUSS,JOE
     URGENCY:                            STATUS: COMPLETED

Provided Mr. Doe with Diabetes diet pamphlet and explained areas
he especially needed to be concerned about.

/es/ Joe E. Ruell, MD
for Stuart Dent, MS3
Medical Student III

          + Next Screen  - Prev Screen  ?? More actions
     Find                Make Addendum          Identify Signers
     Print               Sign/Cosign            Delete
     Edit                Copy                   Link…
                                                Quit
Select Action: Quit//
```

5. Select one of the actions to perform on the document (e.g., edit, sign, make addendum).

All MY UNSIGNED Documents

When you choose this option from the Integrated Document Management Menu, all your unsigned documents are displayed to review, edit, or sign.

Steps to use option:

1. Select *All MY UNSIGNED Documents* from your Integrated Document Management menu on your TIU menu.

```
Select Integrated Document Management Option: All MY UNSIGNED
Documents
Searching for the documents.
```

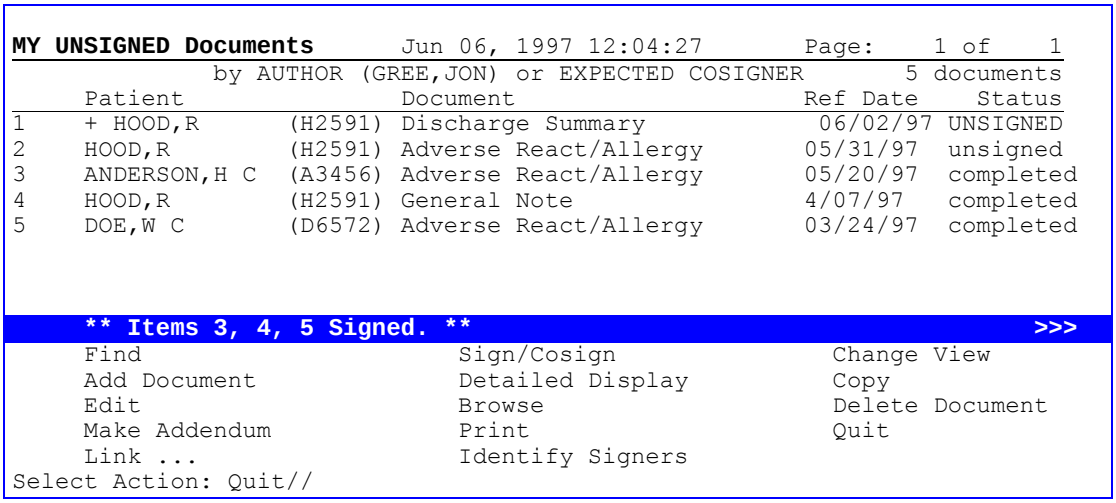
2. After all your unsigned documents are displayed, you can select an action such as add, edit, or sign/cosign, etc.

```
MY UNSIGNED Documents        June 31, 1997 15:38:13          Page:    1 of    1
                by AUTHOR (GRIN,JOE ) or EXPECTED COSIGNER      4 documents
     Patient                  Document                        Ref Date  Status
1    + HOOD,R          (H2591) Discharge Summary              06/02/97  UNSIGNED
2    HOOD,R            (H2591) Adverse React/Allergy          05/31/97  unsigned
3    ANDERSON,H C      (A3456) Adverse React/Allergy          05/20/97  unsigned
4    HOOD,R            (H2591) General Note                   04/07/97  unsigned
5   DOE,W C           (D6572) Adverse React/Allergy          03/24/97  unsigned

     + Next Screen  - Prev Screen  ?? More actions
     Find                        Sign/Cosign                 Change View
     Add Document                Detailed Display            Copy
     Edit                        Browse                      Delete Document
     Make Addendum               Print                       Quit
     Link ...                    Identify Signers
Select Action: Quit// s  Sign/Cosign
Select Document(s):  (1-5): 3-5
Opening Adverse React/Allergy record for review...

SIGN/COSIGN                  Jun 06, 1997 12:03:52          Page:    1 of    1
                              Adverse React/Allergy
ANDERSON,H C   321-12-3456   2B                  Visit Date: 09/21/95@10:00
_____________________________________________________________________________
DATE OF NOTE: MAY 20, 1997@10:51:18  ENTRY DATE: MAY 20, 1997@10:51:18
      AUTHOR: GREEN,JOANN          EXP COSIGNER:
     URGENCY:                            STATUS: UNSIGNED

MORE TESTS ORDERED

     + Next Screen  - Prev Screen  ?? More actions
     Print                                                   No
Ready for Signature: NO// y   Yes
Item #: 3 Added to signature list.
```

All MY UNSIGNED Documents, cont'd

```
Opening General Note record for review...
SIGN/COSIGN                Jun 06, 1997 12:04:59        Page:    1 of    1
                                  General Note
HOOD,R          603-04-2591P  2B                 Visit Date: 05/28/96@15:58

DATE OF NOTE: APR 07, 1997@15:50:26  ENTRY DATE: APR 07, 1997@15:37:25
      AUTHOR: GREEN,JOANN          EXP COSIGNER:
     URGENCY:                            STATUS: UNSIGNED

general malaise

          + Next Screen  - Prev Screen  ?? More actions
     Print                                                      No
Ready for Signature: NO// y   Yes
Item #: 4 Added to signature list.

Opening Adverse React/Allergy record for review...

SIGN/COSIGN                Jun 06, 1997 12:04:10        Page:    1 of    1
                                  Adverse React/Allergy
DOE,W C         243-23-6572                        Visit Date:
07/22/91@11:06

DATE OF NOTE: MAR 24, 1997@11:03:39  ENTRY DATE: MAR 24, 1997@11:03:39
      AUTHOR: GREEN,JOANN          EXP COSIGNER:
     URGENCY:                            STATUS: UNSIGNED

Hay fever reactions severe – antihistamines not working. Prescribed new
medication.

        + Next Screen  - Prev Screen  ?? More actions
     Print                                                      No
Ready for Signature: NO// y   Yes
Item #: 5 Added to signature list.

Enter your Current Signature Code: XXX   SIGNATURE VERIFIED......
```

All MY UNSIGNED Documents, cont'd



Multiple Patient Documents

Use this option to see an integrated Review Screen of all TIU documents.

☞**Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone.

Steps to use option:

1. Select *Multiple Patient Documents* from your Integrated Document Management menu on your TIU menu.

```
Select Integrated Document Management Option: Multiple Patient
Documents
```

2. Select one or more of the following statuses.

```
 1    undictated                          6    uncosigned
 2    untranscribed                       7    completed
 3    unreleased                          8    amended
 4    unverified                          9    purged
 5    unsigned                           10    deleted
Enter selection(s) by typing the name(s), number(s), or
abbreviation(s).
```

```
Select Status: UNSIGNED// <Enter>
```

3. Select a document type (from whatever you have set up at your site):

```
Select Clinical Documents Type(s): 1-3   Addendum
                                   Discharge Summary
                                   Progress Notes
```

4. Select one of the following search categories

```
 1    All Categories       5    Patient          9   Title
 2    Author               6    Problem         10   Transcriptionist
 3    Expected Cosigner    7    Service         11   Treating Specialty
 4    Hospital Location    8    Subject         12   Visit
Enter selection(s) by typing the name(s), number(s), or abbreviation(s).
```

```
Select SEARCH CATEGORIES: AUTHOR// <Enter>
Select AUTHOR: GRIN, JOE    jg
```

5. Enter a date range.

```
Start Reference Date [Time]: T-7// T-60  (APR 01, 1997)
Ending Reference Date [Time]: NOW// <Enter>  (MAY 31, 1997@15:42)
Searching for the documents.
```

6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document to perform it on.

```
UNSIGNED Documents          May 31, 1997 15:42:40        Page: 1 of    1
          by AUTHOR (GRIN,JOE) from 04/01/97 to 05/31/97    3 documents
   Patient                Document                       Ref Date  Status
1  HOOD,R       (H2591)  Adverse React/Allergy          05/31/97  unsigned
2  ANDERSON,H C(A3456)  Adverse React/Allergy          05/20/97  unsigned
3  HOOD,R       (H2591)  General Note                   04/07/97  unsigned

          + Next Screen  - Prev Screen  ?? More actions
   Find                      Sign/Cosign                Change View
   Add Document              Detailed Display           Copy
   Edit                      Browse                     Delete Document
   Make Addendum             Print                      Quit
   Link ...                  Identify Signers
Select Action: Quit//
```

Enter/Edit Document

This option lets you enter and edit clinical documents directly online.

☞ **NOTE:** All documents for outpatients must be associated with a Visit or Admission in order to receive workload credit.

Steps to use option:

1. Select *Enter/Edit Document* from your Integrated Document Management menu on your TIU menu and enter a patient name.

```
Select Integrated Document Management Option: Enter/edit Document
Select PATIENT NAME: DOE,WILLIAM C.    09-12-44   243236572     YES
SC VETERAN
                        A: Known allergies
```

2. Select the Document type.

```
Select TITLE: ??
Choose from:
   ADVANCE DIRECTIVE      TITLE
   ADVERSE REACTION/ALLERGY      TITLE
   CLINICAL WARNING      TITLE
   CRISIS NOTE      TITLE
   DISCHARGE SUMMARY      TITLE

Select TITLE: ADVERSE REACTION/ALLERGY        TITLE
```

3. If the patient is an outpatient, choose the Visit (admission) from the list displayed that you wish to associate with the Adverse Reaction/Allergy note.

All outpatient TIU data has to be associated with a visit. If a visit related to TIU documents already exists, you only need to confirm it; otherwise you'll have to enter a new visit.

```
This patient is not currently admitted to the facility...

Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT// <Enter>

The following VISITS are available:

   1>  APR 18, 1996@10:00                          GENERAL MEDICINE
   2>  FEB 21, 1996@08:40                          PULMONARY CLINIC
   3>  FEB 20, 1996@10:00                          ONCOLOGY
   4>  FEB 20, 1996@08:00                          GENERAL MEDICINE
CHOOSE 1-4 or <N>EW VISIT
<RETURN> TO CONTINUE
OR '^' TO QUIT: 1
```

Enter/Edit Document cont'd

```
Creating new progress note...
          Patient Location:  GENERAL MEDICINE
        Date/time of Visit:  04/18/96 10:00
         Date/time of Note:  NOW
            Author of Note:  GREEN,JOANN
   ...OK? YES// <Enter>

SUBJECT (OPTIONAL description):  <Enter>
Calling text editor, please wait...
  1>Mr. Doe's allergies improved with medication.
  2>
EDIT Option:  <Enter>
Save changes? YES//  <Enter>

Saving Adverse React/Allergy with changes...

Enter your Current Signature Code: xxx   SIGNATURE VERIFIED..
Print this note? No//  <Enter>  NO

You may enter another CLINICAL DOCUMENT. Press RETURN to exit.

Select PATIENT NAME: <Enter>

                    --- Clinician's Menu ---

   1      Individual Patient Document
   2      All MY UNSIGNED Documents
   3      Multiple Patient Documents
   4      Enter/edit Document

Select Integrated Document Management Option: <Enter>
```

Personal Preferences

The two options on this menu let you customize the way TIU operates for you; that is, which prompts will appear, what lists you will see to select from, etc. Thus, if you only work with Discharge Summaries or Progress Notes, or only a specific set within these categories, you can set your preferences so that only these documents appear on selection lists. You can also specify the way documents are displayed on your review screens: by patient, by author, by type, in chronological or reverse chronological order, etc.

If you require cosignatures on your documents (for example, because you're a medical student, PA, or some other category that your site has designated as needing cosignature), you can designate your "Default Cosigner" and then this person will be the default when you're prompted for the Expected Cosigner.

Option	Description
Personal Preferences	Specify defaults that you want in TIU (e.g., Default Location, Sort Order, Display Menus, Patient Selection Preference, etc.)
Document List Management	Specify your "pick lists" for document selection when composing or editing documents.

Personal Preferences

Steps to use option:

1. Select *Personal Preferences* from your TIU menu.

```
Select Progress Notes/Discharge Summary [TIU] Option: Personal Preferences

   1      Personal Preferences
   2      Document List Management
Select Personal Preferences Option: 1  Personal Preferences
```

2. Select *Personal Preferences* from your Personal Preferences menu.

3. Answer the following prompts, as appropriate.

```
Select Personal Preferences Option: Personal Preferences
   Enter/edit Personal Preferences for GREN,JO     JG
  Are you adding 'GREN,JO' as
    a new TIU PERSONAL PREFERENCES (the 5TH)? y  (Yes)
DEFAULT LOCATION: Cardiology Clinic
REVIEW SCREEN SORT FIELD: ?
 Specify the attribute by which the document list should be sorted.
     Choose from:
       P        patient
       D        document type
       R        reference date
       S        status
       C        completion date
       A        author
       E        expected cosigner
REVIEW SCREEN SORT FIELD: p  patient
REVIEW SCREEN SORT ORDER: ?
     Please specify the order in which you want the list sorted
     Choose from:
       A        ascending
       D        descending
REVIEW SCREEN SORT ORDER: a  ascending
DISPLAY MENUS: ?
     Indicate whether menus (for document selection, etc.) should
      be displayed.
     Choose from:
       0        NO
       1        YES
DISPLAY MENUS: 1  YES
PATIENT SELECTION PREFERENCE: ?
     Please indicate your patient selection preference
     Choose from:
       S        single
       M        multiple
PATIENT SELECTION PREFERENCE: m  multiple
DEFAULT COSIGNER: ?
     Indicate which person will usually cosign your Progress Notes.
 Answer with NEW PERSON NAME, or INITIAL, or SSN, or NICK NAME, or DEA#,
   or VA#
 Do you want the entire 66-Entry NEW PERSON List? N
DEFAULT COSIGNER: ANDERS, CURT    ANDERS, CURT,  CA   PHYSICIAN
ASK 'Save changes?' AFTER EDIT: y  YES
ASK SUBJECT FOR PROGRESS NOTES: YES// ??
     Enter YES if you want to be prompted for a SUBJECT when entering or
     editing a Progress Note.  Subject is a freetext, indexed field which
     may help you to find notes about a given topic, etc.
     Choose from:
       1        YES
       0        NO
ASK SUBJECT FOR PROGRESS NOTES: YES// <Enter>
NUMBER OF NOTES ON REV SCREEN: ??
     This determines the number of notes that will be included in your
     initial list when reviewing progress notes by patient.
```

Personal Preferences, cont'd

```
NUMBER OF NOTES ON REV SCREEN: 5??
     Type a Number between 15 and 100
NUMBER OF NOTES ON REV SCREEN: 15
SUPPRESS REVIEW NOTES PROMPT: ??
     Allows user to specify whether to suppress the prompt to
     Review Existing Notes on entry of a Progress Note. YES will
     SUPPRESS the prompt, while NO, or no entry will allow the
     site's default setting to take precedence.
     Choose from:
       1        YES
       0        NO
SUPPRESS REVIEW NOTES PROMPT: 0
Select DAY OF WEEK: Monday
 Are you adding 'Monday' as a new DAY OF WEEK (the 1ST for this
TIU PERSONAL PREFERENCES)? Y  (Yes)
  HOSPITAL LOCATION: GENERAL MEDICINE        ANDERS,CURT
Select DAY OF WEEK: <Enter>
   1      Personal Preferences
   2      Document List Management
```

Document List Management

This option lets you specify which types (Titles) of documents you wish to choose from when asked to select from a given Class (e.g., Discharge Summary or Progress Notes). Then when you create a Progress Note, you will be prompted to select from the specified list of Titles, say, Lipid Clinic Note, History & Physical, Interservice Transfer Note, and Discharge Planning, in that order. This option also lets you specify a default title for the selected Class.

Steps to use option:

1. Select *Document List Management* from your Personal Preferences Menu on your TIU menu.

```
Select Personal Preferences Option: 2  Document List Management
        --- Personal Document Lists ---

This option allows you to create and maintain lists of TITLES for
any of the active CLASSES of documents supported by TIU at your
site.

Explain Details? NO// y  YES

When you use the option to enter a document belonging to a given
class, you will be asked to select a TITLE belonging to that
class.
```

```
For any particular class, you may find that you only wish to
choose from among a few highly specific titles (e.g., if you are a
Pulmonologist entering a PROGRESS NOTE, you may wish to choose
from a short list of three or four titles related to Pulmonary
Function, or Pulmonary Disease).

Rather than presenting you with a list of hundreds of unrelated
titles, TIU will present you with the list you name here.

In the event that you need to select a TITLE which doesn't appear
on your list, you will always be able to do so.
NOTE:  If you expect to enter a single title, or would be unduly
restricted by use of a short list, then we recommend that you
bypass the creation of a list, and simply enter a DEFAULT TITLE
for the class. This option will afford you the opportunity to do
so.
```

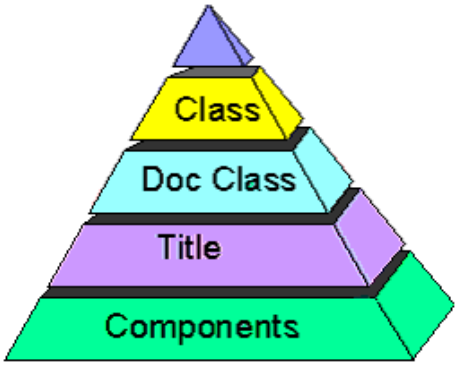
2. Answer the following prompts, as appropriate.

```
Enter/edit Personal Document List for JON GREE
Add a new Personal Document List? YES// <Enter>
CLASS: ?
     Please select the parent group to which the document list
     belongs. You may only pick CLASSES of documents at this
     prompt.
     Answer with TIU DOCUMENT DEFINITION NAME, or ABBREVIATION,
     or PRINT NAME
 Do you want the entire TIU DOCUMENT DEFINITION List? y  (Yes)
Choose from:
   DISCHARGE SUMMARY      CLASS
   PROGRESS NOTES      CLASS
CLASS: Progress Notes
Edit (L)ist, (D)efault TITLE, or (B)oth? BOTH// <Enter>  both

When selecting from this PARENT CLASS, which TITLES would you
like to be presented with initially?

Select TITLE: PSYCHOLOGY - CRISIS
Select TITLE: PSYCHOLOGY - FAMILY THERAPY
Select TITLE: PSYCHOLOGY - NURSING NOTE
Select TITLE: NURSING NOTES - ENCOUNTER GROUP

Now, Specify the TITLE you'd like as your DEFAULT for PROGRESS
NOTES

DEFAULT TITLE: ??
     This determines what TITLE will be offered by default when
     selecting from a given parent class (e.g., when entering a
     PROGRESS NOTE, you may want the DEFAULT TITLE to be DIABETES
     EDUCATION, etc.).
```

```
DEFAULT TITLE: PSYCHOLOGY
     1   PSYCHOLOGY - BEHAV MED          TITLE
     2   PSYCHOLOGY - BIOFEEDBACK          TITLE
     3   PSYCHOLOGY - CRISIS          TITLE
     4   PSYCHOLOGY - FAMILY THERAPY          TITLE
     5   PSYCHOLOGY - IP SATC          TITLE
TYPE '^' TO STOP, OR
CHOOSE 1-5: 3

Select PERSONAL DOCUMENT LIST Name: SUBSTANCE ABUSE
     1   SUBSTANCE ABUSE          TITLE
     2   SUBSTANCE ABUSE COMMITTEE          TITLE
     3   SUBSTANCE ABUSE TLC          TITLE
     4   SUBSTANCE ABUSE TREATMENT CENTER CONSULT          TITLE
CHOOSE 1-4: 1
  Are you adding 'SUBSTANCE ABUSE' as
    a new PERSONAL DOCUMENT LIST (the 1ST for this TIU PERSONAL
DOCUMENT TYPE LIST)? Y    (Yes)
  SEQUENCE: 1
  DISPLAY NAME: SUBSTANCE ABUSE
```

Document Definitions (Clinician)

TIU uses a structure called Document Definitions to organize Progress Notes, Discharge Summaries, and other documents. It contains the Document Definition Hierarchy, which allows documents (Titles) to inherit characteristics of the higher levels, Class and Document Class, such as signature requirements and print characteristics. This structure creates the capability for better integration, shared use of boilerplate text, components, and objects, and a more manageable organization of documents. End users (clinical, administrative, and MIS staff) need not be aware of the hierarchy. They work at the Title level, with the actual documents.



The Document Definitions menu for Clinicians may be assigned to those clinicians who are interested in creating and editing boilerplate text or in viewing or editing Document Definition entries (Class, Document Class, or Title). You can also view available Objects that can be embedded in boilerplate text. See your Clinical Coordinator or the TIU Implementation Guide if you need further information about these options or descriptions of Document Definition concepts.

Option	Description
Edit Document Definitions	This option lets you view and edit entries. Entries are presented in hierarchy order. Items of an entry are in Sequence order, or if they have no Sequence, in alphabetic order by Menu Text, and are indented below the entry. Since Objects don't belong to the hierarchy, they can't be viewed/edited using the Edit Option.
Sort Document Definitions	The Sort option lets you view and edit entries, by sort criteria. It then displays selected entries in alphabetic order by Name, rather than in hierarchy order. Depending on sort criteria, entries can include Objects.
View Objects	The option displays Objects within selected Start With and Go To values in alphabetic order by Name.

Edit Document Definitions

This example shows you how to traverse the hierarchy to see details about a Title in Document Definitions, in this case, an Advance Directive. The first screen shows just the top level of document types. A + indicates that there are items under that document type. To see these, select Expand/Collapse, then enter the number of the document type to be expanded.

```
Select Document Definitions (Clinician) Option: 1  Edit Document Definitions
Edit Document Definitions      Apr 17, 1997 16:42:53        Page:  1 of    1
                                      BASICS

        Name                                                              Type
1       CLINICAL DOCUMENTS                                                 CL
2        +DISCHARGE SUMMARY                                                CL
3        +PROGRESS NOTES                                                   CL
4        +ADDENDUM                                                         DC




     ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-                    >>>
     Expand/Collapse           Detailed Display          Quit
     Jump to Document Def      Try
     Boilerplate Text          Find
Select Action: Quit// e   Expand/Collapse
Select Entry:  (1-4): 3........
```

```
Edit Document Definitions      Apr 17, 1997 16:43:56       Page:    1 of    1
                                      BASICS

        Name                                                             Type
1       CLINICAL DOCUMENTS                                                CL
2        +DISCHARGE SUMMARY                                               CL
3         PROGRESS NOTES                                                  CL
4          +ADVANCE DIRECTIVE                                             DC
5          +ADVERSE REACTION/ALLERGY                                      DC
6          +CRISIS NOTE                                                   DC
7          +CLINICAL WARNING                                              DC
8          +HISTORICAL TITLES                                             DC
9        +ADDENDUM                                                        DC




     ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-                    >>>
     Expand/Collapse           Detailed Display          Quit
     Jump to Document Def      Try
     Boilerplate Text          Find
Select Action: Quit// Expand/Collapse=4
```

Shortcut:
Enter action, =, and the item number

Edit Document Definitions, cont'd

```
Edit Document Definitions   Apr 17, 1997 16:44:17          Page:  1 of    1
                                    BASICS

       Name                                                              Type
1      CLINICAL DOCUMENTS                                                CL
2       +DISCHARGE SUMMARY                                               CL
3        PROGRESS NOTES                                                  CL
4          ADVANCE DIRECTIVE                                             DC
5            ADVANCE DIRECTIVE                                           TL
6           +ADVERSE REACTION/ALLERGY                                    DC
7           +CRISIS NOTE                                                 DC
8           +CLINICAL WARNING                                            DC
9           +HISTORICAL TITLES                                           DC
10      +ADDENDUM                                                        DC



       ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-                >>>
     Expand/Collapse           Detailed Display          Quit
     Jump to Document Def      Try
     Boilerplate Text          Find
Select Action: Quit// DET   DETAILED DISPLAY
Select Entry:  (1-11): 5
```

```
 Non-Owner; View Only

Press RETURN to continue or '^' or '^^' to exit: <Enter>
Detailed Display            Apr 17, 1997 16:44:31        Page:    1 of    1
                            Title ADVANCE DIRECTIVE

  Basics             Note: Values preceded by * have been inherited
            Name:    ADVANCE DIRECTIVE
    Abbreviation:    ADIR
      Print Name:    ADVANCE DIRECTIVE
            Type:    TITLE
        National
        Standard:    YES
          Status:    ACTIVE
           Owner:    CLINICAL COORDINATOR
          In Use:    YES

  Items

  Boilerplate Text

         ? Help       +, - Next, Previous Screen     PS/PL
     Try                        Find                      Quit
Select Action: Quit//
```

View Objects

This option displays Objects in alphabetical order by Name. You can print all available Objects from your site, or specific ones.

```
--- Clinician Document Definition Menu ---


   Edit Document Definitions
   Sort Document Definitions
   View Objects

Select Document Definitions (Clinician) Option: 3  View Objects


START WITH OBJECT: FIRST// <Enter>.....................................
```

```
Objects                        Apr 17, 1997 11:57:57          Page:    1 of    3
Objects

Name                                                                      Status
1.  ACTIVE MEDICATIONS                                                     A
2.  ALLERGIES/ADR                                                          A
3.  BLOOD PRESSURE                                                         A
4.  CURRENT ADMISSION                                                      A
5.  NOW                                                                    A
6.  PATIENT AGE                                                            I
7.  PATIENT DATE OF BIRTH                                                  A
8.  PATIENT DATE OF DEATH                                                  A
9.  PATIENT HEIGHT                                                         A
10. PATIENT NAME                                                           A
11. PATIENT RACE                                                           A
12. PATIENT SEX                                                            A
13. PATIENT SSN                                                            A
14. PATIENT WEIGHT                                                         A
15. PULSE                                                                  A
16. RESPIRATION                                                            A
17. TEMPERATURE                                                            A
18. TODAY'S DATE                                                           A
19. VISIT DATE                                                             A

+         ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-         >>>
Find                        Detailed Display          Quit
Change View
Select Action: Next Screen//
```

TIU and Health Summary

A new Health Summary component is available (through Patch GMTS*2.7*12), *Selected Progress Notes*, which allows selection of specific Progress Notes Titles for display on Health Summaries. Patch GMTS*2.7*45, *Interdisciplinary Progress Notes*, expands this functionality to include Interdisciplinary Notes.

All Progress Notes, Discharge Summary, and CWAD components now extract data from TIU, rather than Progress Notes (GMRP), or Discharge Summary (GMRD).

Care has been taken to assure that the formatting and content of the components have remained the same, except that the signature block information will now reflect the author's (and cosigner's) name and title at the time of signature, rather than displaying their current values at the time of output.

Chapter 4: TIU for MRTs

- **Individual Patient Document**
- **Multiple Patient Documents**
- **Review Upload Filing Events**
- **Print Document Menu**
- **Released/Unverified Report**
- **Search for Selected Documents**

Chapter 4: TIU for Medical Record Technicians

Medical Record Technicians in the MIS or HIMS of Medical Administration Service complete the tasks of assuring that all discharge summaries placed in a patient's medical record have been verified for accuracy and completion. They are also responsible for assuring that a permanent chart copy has been placed in a patient's medical record for each separate admission to the hospital.

MRT Menu

This is the main TIU menu for Medical Record Technicians (MRTs). It includes all of the options necessary for MRTs to review, edit, sign, and print documents, print reports on TIU documents, search for documents, and review upload filing events.

Option	Description
Individual Patient Document	This option allows MRTs to review, edit, or sign patient Documents.
Multiple Patient Documents	Text Integration Utilities review screen of all types of TIU documents available for MRTs.
Review Upload Filing Events	This option lets MRTs generate a list of all upload filing events (i.e., successes, filing errors, or missing field errors) by status, by date range, and to print the corresponding error records or resolve the error (e.g., correct the Patient SSN or Admission date), and retry the filer.
Print Document Menu ...	This menu lets MAS personnel print chart or work copies of discharge summaries, progress notes, or mixed Documents.
Released/Unverified Report	This report gives information on documents for a specified time period that have been released from transcription but still aren't verified. This menu action can be eliminated if Transcription Release or MAS Verification parameters are not enabled.
Search for Selected Documents	Allows MRT's to generate lists of selected documents by extended search criteria (e.g., status, search category, and reference date range). These can then be reviewed individually or by groups, verified, sent back to transcription, reassigned, or printed.

Individual Patient Document

Use this option to review, verify, print or other actions an MRT can perform on clinical documents for a selected patient.

Steps to use option:

1. Select *Individual Patient Document* from the TIU MRT menu, and then enter a patient name to view documents for.

If the patient has Cautions, Warnings, Allergies, or Directives (CWAD), they are displayed here. In this case, the patient has a Warning (W).

```
Select Text Integration Utilities (MRT) Option: 1  Individual Patient
Document
Select PATIENT NAME: DOE,William C        243-23-6572   1A      YES    SC
VETERAN
  (2 notes)  W: 05/28/96 12:33
Available documents:  10/24/96 thru 10/28/96  (3)
```

2. Enter a date range, then choose a document from the list.

```
Please specify a date range from which to select documents:
List documents Beginning: 02/17/96// <Enter>  (FEB 17, 1992)
                     Thru: 10/28/96//<Enter>    (OCT 28, 1996)
1   10/28/96 17:11  BP TEST                              Doogey Howser, MD
                      Adm: 07/22/91  Dis: 02/12/96
2   10/25/96 11:32  Psychology - Crisis                  JON GREE
                      Adm: 10/25/96
Choose documents:  (1-6): 1
```

3. The selected document is displayed. You may press Enter to see the remaining two pages, or choose an action to perform.

```
Browse Document          Oct 30, 1996 10:33:54       Page:   1 of    3
                                BP TEST
DOE,W C        243-23-6572   1A             Visit Date: 07/22/91@11:06

DATE OF NOTE: OCT 28, 1996@17:11:51  ENTRY DATE: OCT 28, 1996@17:11:51
      AUTHOR: HOWSER,DOOGEY        EXP COSIGNER:
     URGENCY:                            STATUS: COMPLETED

     NAME: DOE,WILLIAM C.
      SEX: MALE
      DOB: SEP 12,1944
ALLERGIES: Amoxicillin, Aspirin, MILK
     LABS:
WBC 8.7, RBC 5.1, HGB 16, HCT 47, MCV 91, MCH 29, MCHC 34, Plt  320
     + Next Screen  - Prev Screen  ?? More Actions        >>>
     Find                      Edit                      Copy
     Verify/Unverify           Send Back                 Print
     On Chart                  Reassign                  Quit
Select Action: Next Screen//
```

Multiple Patient Documents

Use this option to display TIU documents of selected types, which can then be individually or multiply reviewed, verified, sent back to transcription, reassigned, or printed.

☞ **Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone.

Steps to use option:

1. Select *Multiple Patient Documents* from your TIU menu.

2. Select one or more of the following statuses.

1	undictated	6	uncosigned
2	untranscribed	7	completed
3	unreleased	8	amended
4	unverified	9	purged
5	unsigned	10	deleted

Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

```
Select Status: UNSIGNED// 4   UNVERIFIED
```

3. Select one of the following types (these may be different at your site):

- Addendum
- Discharge Summary
- Progress Notes

```
Select Clinical Documents Type(s): All Addendum, Discharge Summary,
Progress Notes
```

4. Select one of the following search categories

1	All Categories	5	Patient	9	Title
2	Author	6	Problem	10	Transcriptionist
3	Expected Cosigner	7	Service	11	Treating Specialty
4	Hospital Location	8	Subject	12	Visit

Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

```
Select SEARCH CATEGORIES: AUTHOR// all   All Categories
```

5. Enter a date range.

```
Start Entry Date [Time]: T-7// t-30  (May 02, 1997)
Ending Entry Date [Time]: NOW// <Enter>   (JUN 02, 1997@14:31)
Searching for the documents.............
```

6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document.

Verify action example

```
UNVERIFIED Documents        Jun 02, 1997 14:31:12      Page:  1 of    1
                          from 05/02/97 to 06/02/97          9 documents
   Patient                    Document                    Admitted  Disch'd
1  DRAGON,P          (D1255)  Adverse React/Allergy       05/03/97  05/31/97
2  DOE,W C           (D6572)  ADVANCE DIRECTIVE           05/18/96
3  ANDERSON,H C      (A3456)  ADVANCE DIRECTIVE           08/14/95
4  *+ SMITH,S        (S1462)  Discharge Summary           05/04/92  05/31/97
5  + ANDERSON,H C    (A3456)  Discharge Summary           09/21/95
6 *+ DOE,W C         (D6572)  Discharge Summary           07/22/91  05/12/97

      + Next Screen  - Prev Screen  ?? More Actions                 >>>
     Find                        Reassign                    Print
     Verify/Unverify             Send Back                   Change View
     On Chart                    Detailed Display            Quit
     Edit                        Browse
Select Action: Quit// V    Verify/Unverify
Select Document(s):  (1-3): 4
Opening Discharge Summary record for review...
```

7. The selected document is displayed for you to verify.

```
Verify Document             Jun 02, 1997 14:38:22       Page:    1 of   20
                                  Discharge Summary
SMITH,S         777-45-1462    1A            Adm: 05/04/92  Dis: 05/31/97

   DICT DATE: MAY 25, 1997              ENTRY DATE: MAY 26, 1997@08:54:19
 DICTATED BY: HOWSER,DOOGEY              ATTENDING: RUSSELL,JOEL
     URGENCY: priority                       STATUS: UNVERIFIED
*** Discharge Summary Has ADDENDA ***

DIAGNOSIS:
1.  Status post head trauma with brain contusion.
2.  Status post cerebrovascular accident.
3.  End stage renal disease on hemodialysis.
4.  Coronary artery disease.
+             + Next Screen      - Prev Screen       ?? More actions
     Find                        Verify/Unverify
     Print                       Quit
Select Action: Next Screen// v  Verify/Unverify
Do you want to edit this Discharge Summary? NO// <Enter>
VERIFY this Discharge Summary? NO// y  YES
Discharge Summary VERIFIED
Chart copy queued.
Refreshing the list.
```

Review Upload Filing Events

Steps to use option:

1. Select *Review Upload Filing Events* from the TIU MRT menu.

```
Select Text Integration Utilities (MRT) Option:  Review Upload Filing
Events
```

2. Select the event type to be displayed.

```
Select Event Type: FILING ERRORS// ?

Enter a code from the list.

     Select one of the following:

          F         Filing Errors
          M         Missing Field Errors
          S         Successes
          A         All Events

Select Event Type: FILING ERRORS// <Enter>  Filing Errors
```

3. Select the Resolution Status (Unresolved Errors, Resolved Errors, or All Errors).

```
Select Resolution Status: UNRESOLVED// ?

Enter a code from the list.

     Select one of the following:

          U         Unresolved Errors
          R         Resolved Errors
          A         All Errors

Select Resolution Status: UNRESOLVED// <Enter>  Unresolved Errors
```

4. Enter the range of dates.

```
 Start Event Date [Time]: T-30// <Enter> (MAY 27, 1996)
Ending Event Date [Time]: NOW// <Enter>
Searching for the events.....
```

5. All the documents for the criteria selected are displayed. Choose an action to perform, then the document to perform it on.

```
Filing Events              Jun 26, 1996 09:07:53     Page:    1 of    1
               RESOLVED FILING EVENTS from 05/27/96 to 06/26/96
     Document Type                    Event Type           Event Date/time
1 DISCHARGE SUMMARY                   Filing Error          06/06/96 13:29
  FILING ERROR: STAT DISCHARGE SUMMARY  Record could not be found or
created.
2 PROGRESS NOTES                      Filing Error          06/06/96 14:39




     + Next Screen  - Prev Screen  ?? More Actions        >>>
     Find                         Print event              Quit
     Display/Fix                  Change view
Select Action: Next Screen// Display/Fix=1-2
```

Print Document Menu

This menu contains options that print chart or work copies of discharge summaries, progress notes, or mixed documents.

```
   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print
```

Discharge Summary Print

Use this option to print chart or work copies of discharge summaries.

Steps to use this option:

1. Select *Discharge Summary Print* from the MIS Manager's Print Document Menu.

2. Enter the name of the patient whose discharge summary you want to print.

```
   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print

Select Print Document Menu Option: 1  Discharge Summary Print
Select PATIENT NAME: DOE,WILLIAM C.     09-12-44     243236572     YES
SC VETERAN
             (2 notes)  C: 05/28/96 12:37
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies
             (2 notes)  D: 05/28/96 12:36

Available summaries:  02/12/96 thru 02/12/96  (1)
```

3. Enter the range of dates from which to choose the discharge summary or summaries you want to print.

```
Please specify a date range from which to select summaries:
List summaries Beginning: 02/12/96//   <Enter> (FEB 12, 1996)
                    Thru: 02/12/96// <Enter>

1   02/12/96 13:56  Discharge Summary               Doogey Howser, MD
                      Adm: 07/22/91  Dis: 02/12/96

Choose summaries:  (1-1): 1
Do you want WORK copies or CHART copies? CHART// WORK
DEVICE: HOME//  <Enter>  VAX
```

Discharge Summary Print Example

```
SALT LAKE CITY   priority                        06/27/96 08:45       Page:  1
-------------------------------------------------------------------------------
PATIENT NAME                  | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
DOE,WILLIAM C.                |  51 |  M  | MEXI | 243-23-6572 |
-------------------------------------------------------------------------------
  ADM DATE   |  DISC DATE   | TYPE OF RELEASE   | INP | ABS | WARD NO
JUL 22, 1991 | FEB 12, 1996 | REGULAR           |1666 |   0 | 1A
-------------------------------------------------------------------------------
DICTATION DATE: JUN 09, 1996            TRANSCRIPTION DATE: JUN 12, 1996
TRANSCRIPTIONIST: bs

DIAGNOSIS:

1.  Status post head trauma with brain contusion.
2.  Status post cerebrovascular accident.
3.  End stage renal disease on hemodialysis.
4.  Coronary artery disease.
5.  Congestive heart failure.
6.  Hypertension.
7.  Non insulin dependent diabetes mellitus.
8.  Peripheral vascular disease, status post thrombectomies.
9.  Diabetic retinopathy.
10. Below knee amputation.
11. Chronic anemia.

OPERATIONS/PROCEDURES:
1. MRI.
2. CT SCAN OF HEAD.

HISTORY OF PRESENT ILLNESS:
Patient is a 49-year-old, white male with past medical history of end stage
renal disease, peripheral vascular disease, status post BKA, coronary artery
disease, hypertension, non insulin dependent diabetes mellitus, diabetic
retinopathy, congestive heart failure, status post CVA, status post
thrombectomy admitted from Anytown VA after a fall from his wheelchair in the
hospital.  He had questionable short lasting loss of consciousness but patient
is not very sure what has happened.  He denies headache, vomiting, vertigo.
On admission patient had CT scan which showed a small area of parenchymal
hemorrhage in the right temporal lobe which is most likely consistent with
hemorrhagic contusion without mid line shift or incoordination.

ACTIVE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Coumadin 2.5 mgs p.o. qd,
ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15
ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d. with food, Betoptic
0.5% ophthalmologic solution gtt OU b.i.d., Nephrocaps 1 tablet p.o. qd,
Pilocarpine 4% solution 1 gtt OU b.i.d., Compazine 10 mgs p.o. t.i.d. prn
nausea, Tylenol 650 mgs p.o. q4 hours prn.

Patient is on hemodialysis, no known drug allergies.

PHYSICAL EXAMINATION:  Patient had stable vital signs, his blood pressure was
160/85, pulse 84, respiratory rate 20, temperature 98 degrees.  Patient was
alert, oriented times three, cooperative.  His speech was fluent,
understanding of spoken language was good.  Attention span was good.  He had
                                                                    D R A F T
Press RETURN to continue or '^' to exit: <Enter>
```

Discharge Summary Print Example cont'd

```
SALT LAKE CITY   priority                        06/27/96 08:46       Page:  4
-------------------------------------------------------------------------------
PATIENT NAME                  | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
DOE,WILLIAM C.                |  51 |  M  | MEXI | 243-23-6572 |
-------------------------------------------------------------------------------
moderate memory impairment, no apraxia noted.  Cranial nerves patient was
blind, pupils are not reactive to light, face was asymmetric, tongue and
palate are mid line.  Motor examination showed muscle tone and bulk without
significant changes.  Muscle strength in upper extremities 5/5 bilaterally,
sensory examination revealed intact light touch, pinprick and vibratory
sensation.  Reflexes 1+ in upper extremities, coordination finger to nose test
within normal limits bilaterally.  Alternating movements without significant
changes bilaterally.  Neck was supple.

LABORATORY:  Showed sodium level 135, potassium 4.6, chloride 96, CO2 26,
BUN 39, creatinine 5.3, glucose level 138.  White blood cell count was 7,
hemoglobin 11, hematocrit 34, platelet count 77.

HOSPITAL COURSE:  Patient was admitted after head trauma with multiple medical
problems.  His coumadin was held.  Patient had cervical spine x-rays which
showed definite narrowing of C5, C6 interspace, slight retrolisthesis at this
level, prominent spurs at this level as well as above and below.  CT scan on
admission showed a moderate amount of scalp thinning with subcutaneous air
overlying the left frontal lobe.  A small area of left parenchymal hemorrhage
adjacent to the right petros bone in the temporal lobe which most likely
represents a hemorrhagic contusion. Repeated CT scan on 5/13/94 didn't show any
progressive changes.  Patient remained in stable condition.  He had hemodialysis
q.o.d.  He restarted treatment with Coumadin.  His last PT was 11.9, PTT 31.
Patient refused before hemodialysis new blood tests.  His condition remained
stable.

DISCHARGE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Ferrous sulfate 325 mgs
p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium
carbonate 650 mgs p.o. b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Betoptic
0.5% OU b.i.d., Nephrocaps 1 p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d.,
Coumadin 2.5 mgs p.o. qd, Tylenol 650 mgs p.o. q6 hours prn pain.

DISPOSITION/FOLLOW-UP:
Recommend follow PT/PTT.  Patient is on coumadin and CBC with differential
because patient has chronic anemia and thrombocytopenia.
Patient will be transferred to Anytown VA in stable condition on 5/19/94.

WORK COPY ========= UNOFFICIAL - NOT FOR MEDICAL RECORD ======== DO NOT FILE
SIGNATURE PHYSICIAN/DENTIST             SIGNATURE APPROVING PHYSICIAN/DENTIST


Doogey Howser, MD                       Joe E. Ruell, MS
PGY2 Resident                           Medical Internist
========================= CONFIDENTIAL INFORMATION ==========================
                              D R A F T
JUN 26, 1996@17:36:02  ADDENDUM:
Routine visit today--no change to condition.

SIGNATURE PHYSICIAN/DENTIST             SIGNATURE APPROVING PHYSICIAN/DENTIST


                                        Joe E. Ruell, MD
                                        Medical Internist
```

Progress Note Print

Use this option to print chart or work copies of progress notes.

Steps to use option:

1. **Select *Progress Note Print* from the Print Document Menu.**

2. **Enter a patient name.**

```
Select Print Document Menu Option: 2  Progress Note Print
Select PATIENT NAME:  DOE,WILLIAM C.       09-12-44     243236572     YES
SC VETERAN
             (2 notes)  C: 05/28/96 12:37
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies
             (2 notes)  D: 05/28/96 12:36

Available notes:  02/17/96 thru 06/21/96  (31)
```

3. **Enter the range of dates for progress notes you want to print.**

4. **Choose a note from those listed.**

```
Please specify a date range from which to select notes:
List notes Beginning: 02/17/96// <Enter>  (FEB 17, 1996)
                Thru: 06/21/96// <Enter> (JUN 21, 1996)

1   06/21/96 11:40  Lipid Clinic                            Joe Ruell
                    Visit: 02/21/96
2   06/21/96 11:38  Social Work Service                     Joe Ruell
                    Visit: 04/18/96
3   06/07/96 00:00  Diabetes Education                     Doogey Howser MD
                    Visit: 04/18/96
4   05/15/96 13:10  Addendum to Diabetes Education         STEVEN B. WINTER
                    Visit: 02/21/96
5   04/24/96 15:41  Lipid Clinic                            Joe Ruell
                    Visit: 04/24/96
6   02/23/96 14:08  Diabetes Education                      Joe Ruell
                    Visit: 02/21/9
Choose notes:  (1-6):3, 5
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME// <Enter>  VAX
```

Progress Notes Print Example

```
---------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                  Progress Notes
---------------------------------------------------------------------------
NOTE DATED: 06/07/96 17:51    DIABETES EDUCATION
ADMITTED: 07/22/95 11:06 1A
SUBJECT: Routine diabetes education

Patient understanding good.

                  Signed by: /es/ Joe E. Ruell, MD
                                  Medical Internist 06/23/96 08:34
                                  Analog Pager:  555-1213
                                  Digital Pager: 555-1215
                Cosigned by: /es/ SELL,NOEL
                                   06/23/96 08:34
                                  Analog Pager: 555-1213
                                  Digital Pager:555-1215

NOTE DATED: 04/24/96 08:00    ARTERIAL EVALUATION - LOWER EXTREMITY
VISIT: 04/17/92 08:00 CARY'S CLINIC
SUBJECT: Rule out embolus, lower extremity

                AGE:  50
               UNIT:  General Medicine
       REFERRING MD:  Dr. Scholl
          DIAGNOSIS:  Rule out embolus

            HISTORY:  severe pedal edema, foot ulcers

              OTHER:  cyanosis
            SYMPTOMS:
   RESTING SYMPTOMS:
EXERTIONAL SYMPTOMS:
             LESIONS:
        MEDICATIONS:

                              RECORDED                                RECORDED
AUDIBLE DOPPLER SIGNAL    RIGHT   LEFT   DOPPLER WAVEFORM:     RIGHT  LEFT
  COMMON FEMORAL          _____   _____    COMMON FEMORAL      _____  _____

  SUPERFICIAL FEMORAL     _____   _____    PRE-EXERCISE        _____  _____
  POPLITEAL               _____   _____    POST-EXERCISE       _____  _____
  POSTERIOR TIBIAL        _____   _____    OTHER               _____  _____
  DORSALIS PEDIS          _____   _____

   N=NORMAL   ABN=ABNORMAL    O=ABSENT    B=BIPHASIC

TRANSCUTANEOUS PO2 VALUES:
                            RIGHT          LEFT
   SUBCLAVICULAR            ___40___       ___40___
   ABOVE KNEE               ___39___       ___40___
   HIGH BK                  ___39___       ___40___
   CALF                     ___37___       ___39___
   ANKLE                    ___36___       ___39___
   DORSUM OF FOOT           ___22___       ___38___
   OTHER                    ___18___       ___38___
Enter RETURN to continue or '^' to exit: <Enter>
```

Progress Notes Print Example cont'd

```
--------------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                    Progress Notes
--------------------------------------------------------------------------------
04/24/92 08:00       ** CONTINUED FROM PREVIOUS SCREEN **
   40      =ADEQUATE FOR HEALING
   39-30   =EQUIVOCAL FOR HEALING
   29-0    =INADEQUATE FOR HEALING

SEGMENTAL SYSTOLIC BLOOD PRESSURE:
                           RIGHT   INDEX          LEFT    INDEX
   ARM                     _______________        _______________
   HIGH THIGH              _______________        _______________
   ABOVE KNEE              _______________        _______________
   BELOW KNEE              _______________        _______________
   ANKLE  PT               _______________        _______________
   DP                      _______________        _______________


 EXERCISE RESPONSE:

       MPH:     5 mph


       MAXIMUM WALKING TIME:  _10_ MIN _30_ SEC

       SYMPTOMS: Pedal edema, cyanosis

       MAXIMUM HEART RATE ACHIEVED:

          TIME         RIGHT INDEX        LEFT INDEX         ARM

          1 MINUTE     _____________      _____________      _____________
          3 MINUTES    _____________      _____________      _____________
          5 MINUTES    _____________      _____________      _____________
         10 MINUTES    _____________      _____________      _____________
         15 MINUTES    _____________      _____________      _____________
         20 MINUTES    _____________      _____________      _____________

POST EXERCISE:

IMPRESSIONS:

                  Signed by: /es/ Joe E. Ruell, MD
                                  Medical Internist 04/24/96 14:19
                                  Analog Pager:  555-1213
                                  Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit: ^

   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print

Select Print Document Menu Option: <Enter>
```

Clinical Document Print

Use this option to print chart or work copies of all clinical documents available through TIU.

Steps to use option:

1. Select *Clinical Document Print* from the Print Document Menu, and then enter a patient name.

```
Select Print Document Menu Option: 3  Clinical Document Print
Select PATIENT NAME: DOE,WILLIAM C.       09-12-44     243236572     YES
SC VETERAN
            (2 notes)  C: 05/28/96 12:37
            (2 notes)  W: 05/28/96 12:33
                       A: Known allergies
            (2 notes)  D: 05/28/96 12:36

Available documents:  02/17/92 thru 06/21/96  (34)
```

2. Enter a date range that documents will be chosen from.

```
Please specify a date range from which to select documents:
List documents Beginning: 02/17/92// 6/1/96  (JUN 01, 1996)
                  Thru: 06/21/96// 6/8/96  (JUN 08, 1996)

1   06/07/96 00:00  Diabetes Education              Doogey Howser, MD
                    Visit: 04/18/96
2   06/05/96 17:23  Lipid Clinic                              Joe Ruell
                    Visit: 04/18/96
3   06/05/96 11:10  Addendum to Lipid Clinic                  Joe Ruell
                    Visit: 04/24/96
```

3. Choose the document or documents you would like printed, and whether you want work or chart copies.

```
Choose documents:  (1-3): 1-3
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME//  PRINTER
```

4. The document(s) will then be printed at the device you specify.

Clinical Document Print Example

```
---------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                  Progress Notes
---------------------------------------------------------------------------
NOTE DATED: 06/07/96 00:00    DIABETES EDUCATION
VISIT: 04/18/96 10:00 GENERAL MEDICINE
Routine diabetes education given as follow-up to lipid clinic visit.

                  Signed by: /es/ Doogey Howser, MD
                                  PGY2 Resident 06/07/96 10:22


NOTE DATED: 06/05/96 17:23    LIPID CLINIC
VISIT: 04/18/96 10:00 GENERAL MEDICINE
SUBJECTIVE:    51 year old MEXICAN AMERICAN MALE here for
               initial evaluation of his DYSLIPIDEMIA.

PMH:

               Significant negative medical history pertinent to the
               evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION
HISTORY:       CURRENT MEDICATIONS

DIET:          Counseled on AHA Step I diet today by Araceli Neal.
               See her evaluation.

ACTIVITY:

OBJECTIVE:     HT:  72 (08/23/95 11:45)   WT:  190 (08/23/95 11:45)


               TSH/T4: /

                  FBG: 89           HEMOGLOBIN A1C:

                 SGOT:                URIC ACID:

ASSESSMENT:    1.      MALE with / without documented CAD
               2.      CV Risk factors:
               3.      Lipid pattern:

PLAN:          1.      Implement recommendations to lower fat intake.
               2.      Repeat FBG and HBG A1C on:
               3.      Return to review lab on:

                  Signed by: /es/ Joe E. Ruell, MD
                                  Internist  06/05/96 17:23
                                  Analog Pager:  555-1213
                                  Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit: <Enter>
```

Clinical Document Print Example cont'd

```
------------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                   Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 04/24/96 15:41    LIPID CLINIC
VISIT: 04/24/96 15:40 DIABETIC EDUCATION-INDIV-MOD B
SUBJECTIVE:    51 year old MEXICAN AMERICAN MALE here for
               initial evaluation of his DYSLIPIDEMIA.

PMH:

               Significant negative medical history pertinent to the
               evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION
HISTORY:       CURRENT MEDICATIONS

DIET:          Counseled on AHA Step I diet today by Araceli Neal.

               See her evaluation.

ACTIVITY:

OBJECTIVE:     HT:  72 (08/23/95 11:45)   WT:  190 (08/23/95 11:45)


               TSH/T4: /

                  FBG: 89           HEMOGLOBIN A1C:

                 SGOT:                URIC ACID:

ASSESSMENT:    1.      MALE with / without documented CAD
               2.      CV Risk factors:
               3.      Lipid pattern:


PLAN:          1.      Implement recommendations to lower fat intake.
               2.      Repeat FBG and HBG A1C on:
               3.      Return to review lab on:

                  Signed by: /es/ Joe E. Ruell, MD
                                  Internist 04/24/96 15:41
                                  Analog Pager:  555-1213
                                  Digital Pager: 555-1215


Enter RETURN to continue or '^' to exit: <Enter>

   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print
```

Released/Unverified Report

Use this option to produce a list of released documents which haven't been verified.

Steps to use option:

1. Select *Released/Unverified Report* from the MRT menu.

2. Enter the starting day for the report.

3. Specify a printer. If necessary, set the margin width to 132.

```
Select Text Integration Utilities (MRT) Option: Released/Unverified Report
START WITH RELEASE DATE/TIME: FIRST// <Enter>
DEVICE:   PRINTER
       MARGIN WIDTH IS NORMALLY AT LEAST 132
        ARE YOU SURE? No// YES
```

```
Discharge Summary Released/Unverified Report OCT 15,1996  11:59 PAGE 1
PATIENT                          SSN         ADM DATE   DIS DATE
                                 LINE
  DICTATED BY      URGENCY       COUNT
------------------------------------------------------------------------
                   RELEASE DATE/TIME: JAN 10,1996
  TRANSCRIPTIONIST: DP
HOOD,ROBIN                       603042591P  02/27/92   03/05/92
  PRICE,D          routine       1         Discharg
                                 --------
SUBTOTAL                         1
                   RELEASE DATE/TIME: SEP 10,1996
  TRANSCRIPTIONIST: BS
ANDERSON,H C                     321123456   09/21/95
  HOWSER,D         routine       72        Addendum
SMITH,SAM                        777451462   05/04/92   05/31/96
  HOWSER,D         priority      78        Addendum
                                 --------
SUBTOTAL                         150

Discharge Summary Released/Unverified Report OCT 15,1996  11:59 PAGE 2
PATIENT                          SSN         ADM DATE   DIS DATE
                                 LINE
  DICTATED BY      URGENCY       COUNT
------------------------------------------------------------------------
                   RELEASE DATE/TIME: OCT  4,1996
  TRANSCRIPTIONIST: jg
DOE,WILLIAM C.                   243236572   07/22/91   02/12/96
  RUSSELL,J        routine       1         Discharg
                                 --------
SUBTOTAL                         1
                                 --------
TOTAL                            152
Press RETURN to continue...<Enter>
```

Search for Selected Documents

Use this option to produce a list of selected documents by extended search criteria e.g., status, search category, and reference date range). These can then be reviewed, verified, sent back to transcription, reassigned, or printed.

Steps to use option:

1. Select *Search for Selected Documents* from the TIU MRT menu.

2. Select the status of documents you want displayed.

```
Select Text Integration Utilities (MRT) Option: 6  Search for
Selected Documents

Select Status: COMPLETED// ?

1    undictated                          6    uncosigned
2    untranscribed                       7    completed
3    unreleased                          8    amended
4    unverified                          9    purged
5    unsigned                            10   deleted
Enter selection(s) by typing the name(s), number(s), or
abbreviation(s).
Select Status: COMPLETED// <Enter>   completed
```

3. Select the document type you want displayed.

These may be different at your site.

```
Select CLINICAL DOCUMENTS Type(s): Discharge Summaries// ?
1 Discharge Summaries   2 Progress Notes     3  Addendum
Enter selection(s) by typing the name(s), number(s), or
abbreviation(s).
Select CLINICAL DOCUMENTS Type(s):Progress Notes  Progress Notes
```

4. Select the search category you want displayed.

```
Select SEARCH CATEGORIES: AUTHOR// ?
1  All Categories      5    Patient       9   Title
2  Author              6    Problem      10   Transcriptionist
3  Expected Cosigner   7    Service      11   Treating Specialty
4  Hospital Location   8    Subject      12   Visit
Enter selection(s) by typing the name(s), number(s), or
abbreviation(s).
Select SEARCH CATEGORIES: AUTHOR// <Enter>   Author
Select AUTHOR:  GRIN,JOE        JG
```

5. Enter the range of dates you want displayed.

```
 Start Reference Date [Time]: T-7//<Enter>     (MAY 26, 1997)
Ending Reference Date [Time]: NOW// <Enter> (JUN 02, 1997@15:46)
Searching for the documents...
```

6. The documents fitting the search criteria you selected are displayed. Choose an action to perform on the relevant documents.

```
UNSIGNED Documents       Jun 02, 1997 15:46:28          Page:  1 of  1
      by AUTHOR (GRIN,JOE) from 05/26/97 to 06/02/97     2 documents
  Patient                Document                       Ref Date  Status
1 DOE,W C        (D6572) Adverse React/Allergy          05/31/97  unsigned
2 HOOD,R         (H2591) Adverse React/Allergy          05/31/97  unsigned

     + Next Screen      - Prev Screen     ?? More Actions            >>>
   Find                     Reassign                 Print
   Verify/Unverify          Send Back                Change View
   On Chart                 Detailed Display         Quit
   Edit                     Browse
Select Action: Quit//
```

Chapter 5: TIU for MIS/HIMS Managers

- **Individual Patient Document**
- **Multiple Patient Documents**
- **Print Documents Menu**
- **Search for Selected Documents**
- **Statistical Reports**

Chapter 5: TIU for MIS/HIMS Managers

The Medical Information Section (MIS), also called Health Information Management Section (HIMS), maintains and manages records of clinical documents, including copies of statistical reports, and chart or work copies of discharge summaries and progress notes.

MIS Manager's Menu

Option	Description
Individual Patient Document	Allows you to review or print patient Clinical Documents.
Multiple Patient Documents	This option lets MIS Managers see any of the available TIU documents on the Text Integration Utilities Review Screen.
Print Document Menu	This menu gives MAS personnel access to options which print CHART or WORK copies of discharge summaries, progress notes, or mixed Documents on demand.
Search for Selected Documents	Allows MIS Managers to generate a list of selected documents based on extended search criteria; e.g., STATUS, SEARCH CATEGORY, and REFERENCE DATE RANGE).
Statistical Reports	This menu allows you to view or print statistical reports for line counts and timeliness by Author, Transcriptionist, and Service.

Individual Patient Document

Use this option to review or print TIU documents for a patient.

Steps to use option:

1. Select *Individual Patient Document* from the MIS Manager Menu, and then enter the patient name.

```
Select Text Integration Utilities (MIS Manager) Option:  Individual
Patient Document
Select PATIENT NAME: HOOD,ROBIN  04-25-31 603042591P  NO    MILITARY
RETIREE
             (2 notes)  W: 09/16/96 15:12  (addendum 09/18/96 09:53)
                        A: Known allergies

Available documents:  08/11/95 thru 10/10/96  (131)
```

2. Select a date range for the documents you wish to review, and then choose one or more of the documents displayed.

```
Please specify a date range from which to select documents:
List documents Beginning: 08/11/95// t-15  (SEP 30, 1996)
                     Thru: 10/10/96// <Enter>  (OCT 10, 1996)

1   10/06/96 14:11  Addendum to Diabetes Education    Joe E. Ruell, MD
                      Adm: 09/28/96
2   10/05/96 13:56  Diabetes Education                Stuart Dent, MS3
                      Adm: 09/28/96

Choose documents:  (1-3): 2
```

3. The document(s) you chose is displayed. Choose an action to perform.

```
Browse Document              Oct 15, 1996 12:23:42       Page:  1 of    1
                                  Diabetes Education
HOOD,R          603-04-2591P  1A             Visit Date: 09/28/96@15:58

DATE OF NOTE: SEP 05, 1996@13:51:03  ENTRY DATE: SEP 05, 1996@13:51:03
      AUTHOR: DENT,STUART          EXP COSIGNER: RUELL,JOE
     URGENCY:                           STATUS: COMPLETED
TEST DRUG EFFICACY.

/es/ Stuart Dent, MS3                  /es/ Joe E. Ruell, MD
Medical Student III
Signed: 10/05/96 13:51                 Cosigned: 10/05/96 14:11

     + Next Screen  - Prev Screen  ?? More Actions        >>>
     Find                      On Chart                  Reassign
     Print                     Amend                     Send Back
     Edit                      Delete                    Quit
     Verify/Unverify
Select Action: Quit//
```

Multiple Patient Documents

Use this option to display TIU documents of specified types, which can then be reviewed, verified, sent back to transcription, reassigned, or printed.

☞ **Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone. The example below would probably be too broad in a large hospital.

Steps to use option:

1. Select *Multiple Patient Documents* from the MIS Manager menu. Answer the prompts that follow.

These may differ at your site. →

```
Select Text Integration Utilities (MIS MANAGER) Option: Multiple Patient
Documents
Select Status: UNSIGNED// <Enter>    Unsigned
Select Clinical Documents Type(s): ?
1 Progress Notes 2    Discharge Summary         3 Addendum
Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

Select Clinical Documents Type(s): 1-3   Addendum  Discharge Summary
                                   Progress Notes
Select SEARCH CATEGORIES: AUTHOR// all   All Categories
 Start Reference Date [Time]: T-7//t-15 (MAR 19, 1997)
Ending Reference Date [Time]: NOW// <Enter> (APR 18, 1997@15:21)
Searching for the documents.............
```

2. When the documents that fit the criteria you entered are displayed, choose an action and a document(s).

```
UNSIGNED Documents            Apr 18,1996 15:21:44          Page:1 of 1
by ALL CATEGORIES from 03/19/96 to 04/18/96 15 documents
  Patient                    Document            Ref Date       Status
1 ACE,J  (A8101)             Nursing Note        04/15/96       unsigned
2 ADAMS,S (A2760)            Addendum            03/22/96       unsigned
3 ADAMS,S (A2760)            Addendum            03/22/96       unsigned
4 OUTPAT  (O6641)            Ambul/Outp Care     04/18/96       unsigned
5 OUTPAT  (O6641)            General Note        04/18/96       unsigned
6 OUTPAT  (O6641)            Diabetes Ed         03/20/96       unsigned
7 RUSS,D  (R0482)            Diabetes Edu        03/25/96       unsigned
8 RUSS,D  (R0482)            Addendum            03/25/96       unsigned

     Find                        Delete Document          Browse
     On Chart                    Reassign                 Print
     Edit                        Send Back                Change View
     Verify/Unverify             Detailed Display         Quit
     Amend Document
Select Action: Quit// ON CHART
```

Print Document Menu

This menu contains options which print chart or work copies of discharge summaries, progress notes, or mixed documents.

```
   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print
```

Discharge Summary Print

Use this option to print chart or work copies of discharge summaries.

Steps to use this option:

1. Select *Discharge Summary Print* from the MIS Manager's Print Document Menu.

2. Enter the name of the patient whose discharge summary you want to print.

```
   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print

Select Print Document Menu Option: 1  Discharge Summary Print
Select PATIENT NAME: DOE,WILLIAM C.     09-12-44     243236572     YES
SC VETERAN
             (2 notes)  C: 05/28/96 12:37
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies
             (2 notes)  D: 05/28/96 12:36

Available summaries:  02/12/96 thru 02/12/96  (1)
```

3. Enter the range of dates to choose the discharge summary or summaries you want to print.

```
Please specify a date range from which to select summaries:
List summaries Beginning: 02/12/96//   <Enter> (FEB 12, 1996)
                     Thru: 02/12/96// <Enter>

1   02/12/96 13:56  Discharge Summary                Doogey Howser, MD
                      Adm: 07/22/91  Dis: 02/12/96

Choose summaries:  (1-1): 1
Do you want WORK copies or CHART copies? CHART// WORK
DEVICE: HOME//  <Enter>  VAX
```

Discharge Summary Print Example

```
SALT LAKE CITY   priority                        06/27/96 08:45       Page:  1
-------------------------------------------------------------------------------
PATIENT NAME                  | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
DOE,WILLIAM C.                |  51 |  M  | MEXI | 243-23-6572 |
-------------------------------------------------------------------------------
  ADM DATE   |  DISC DATE   | TYPE OF RELEASE   | INP | ABS | WARD NO
JUL 22, 1991 | FEB 12, 1996 | REGULAR           |1666 |   0 | 1A
-------------------------------------------------------------------------------
DICTATION DATE: JUN 09, 1996            TRANSCRIPTION DATE: JUN 12, 1996
TRANSCRIPTIONIST: bs

DIAGNOSIS:

1.  Status post head trauma with brain contusion.
2.  Status post cerebrovascular accident.
3.  End stage renal disease on hemodialysis.
4.  Coronary artery disease.
5.  Congestive heart failure.
6.  Hypertension.
7.  Non insulin dependent diabetes mellitus.
8.  Peripheral vascular disease, status post thrombectomies.
9.  Diabetic retinopathy.
10. Below knee amputation.
11. Chronic anemia.

OPERATIONS/PROCEDURES:
1. MRI.
2. CT SCAN OF HEAD.

HISTORY OF PRESENT ILLNESS:
Patient is a 49-year-old, white male with past medical history of end stage
renal disease, peripheral vascular disease, status post BKA, coronary artery
disease, hypertension, non insulin dependent diabetes mellitus, diabetic
retinopathy, congestive heart failure, status post CVA, status post
thrombectomy admitted from Anytown VA after a fall from his wheelchair in the
hospital.  He had questionable short lasting loss of consciousness but patient
is not very sure what has happened.  He denies headache, vomiting, vertigo.
On admission patient had CT scan which showed a small area of parenchymal
hemorrhage in the right temporal lobe which is most likely consistent with
hemorrhagic contusion without mid line shift or incoordination.

ACTIVE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Coumadin 2.5 mgs p.o. qd,
ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15
ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d. with food, Betoptic
0.5% ophthalmologic solution gtt OU b.i.d., Nephrocaps 1 tablet p.o. qd,
Pilocarpine 4% solution 1 gtt OU b.i.d., Compazine 10 mgs p.o. t.i.d. prn
nausea, Tylenol 650 mgs p.o. q4 hours prn.

Patient is on hemodialysis, no known drug allergies.

PHYSICAL EXAMINATION:  Patient had stable vital signs, his blood pressure was
160/85, pulse 84, respiratory rate 20, temperature 98 degrees.  Patient was
alert, oriented times three, cooperative.  His speech was fluent,
understanding of spoken language was good.  Attention span was good.  He had
                                                                    D R A F T
Press RETURN to continue or '^' to exit: <Enter>
```

Discharge Summary Print Example cont'd

```
SALT LAKE CITY   priority                        06/27/96 08:46       Page:  4
-------------------------------------------------------------------------------
PATIENT NAME                  | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
DOE,WILLIAM C.                |  51 |  M  | MEXI | 243-23-6572 |
-------------------------------------------------------------------------------
moderate memory impairment, no apraxia noted.  Cranial nerves patient was
blind, pupils are not reactive to light, face was asymmetric, tongue and
palate are mid line.  Motor examination showed muscle tone and bulk without
significant changes.  Muscle strength in upper extremities 5/5 bilaterally,
sensory examination revealed intact light touch, pinprick and vibratory
sensation.  Reflexes 1+ in upper extremities, coordination finger to nose test
within normal limits bilaterally.  Alternating movements without significant
changes bilaterally.  Neck was supple.

LABORATORY:  Showed sodium level 135, potassium 4.6, chloride 96, CO2 26,
BUN 39, creatinine 5.3, glucose level 138.  White blood cell count was 7,
hemoglobin 11, hematocrit 34, platelet count 77.

HOSPITAL COURSE:  Patient was admitted after head trauma with multiple medical
problems.  His coumadin was held.  Patient had cervical spine x-rays which
showed definite narrowing of C5, C6 interspace, slight retrolisthesis at this
level, prominent spurs at this level as well as above and below.  CT scan on
admission showed a moderate amount of scalp thinning with subcutaneous air
overlying the left frontal lobe.  A small area of left parenchymal hemorrhage
adjacent to the right petros bone in the temporal lobe which most likely
represents a hemorrhagic contusion. Repeated CT scan on 5/13/94 didn't show any
progressive changes.  Patient remained in stable condition.  He had hemodialysis
q.o.d.  He restarted treatment with Coumadin.  His last PT was 11.9, PTT 31.
Patient refused before hemodialysis new blood tests.  His condition remained
stable.

DISCHARGE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Ferrous sulfate 325 mgs
p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium
carbonate 650 mgs p.o. b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Betoptic
0.5% OU b.i.d., Nephrocaps 1 p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d.,
Coumadin 2.5 mgs p.o. qd, Tylenol 650 mgs p.o. q6 hours prn pain.

DISPOSITION/FOLLOW-UP:
Recommend follow PT/PTT.  Patient is on coumadin and CBC with differential
because patient has chronic anemia and thrombocytopenia.
Patient will be transferred to Anytown VA in stable condition on 5/19/94.

WORK COPY ========= UNOFFICIAL - NOT FOR MEDICAL RECORD ======== DO NOT FILE
SIGNATURE PHYSICIAN/DENTIST             SIGNATURE APPROVING PHYSICIAN/DENTIST


Doogey Howser, MD                       Joe E. Ruell, MS
PGY2 Resident                           Medical Internist
========================= CONFIDENTIAL INFORMATION ==========================
                              D R A F T
JUN 26, 1996@17:36:02  ADDENDUM:
Routine visit today--no change to condition.

SIGNATURE PHYSICIAN/DENTIST             SIGNATURE APPROVING PHYSICIAN/DENTIST


                                        Joe E. Ruell, MD
                                        Medical Internist
```

Progress Note Print

Use this option to print chart or work copies of progress notes.

Steps to use option:

3. **Select *Progress Note Print* from the Print Document Menu.**

4. **Enter a patient name.**

```
Select Print Document Menu Option: 2  Progress Note Print
Select PATIENT NAME:  DOE,WILLIAM C.       09-12-44     243236572     YES
SC VETERAN
             (2 notes)  C: 05/28/96 12:37
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies
             (2 notes)  D: 05/28/96 12:36

Available notes:  02/17/96 thru 06/21/96  (31)
```

5. **Enter the range of dates for progress notes you want to print.**

6. **Choose a note from those listed.**

```
Please specify a date range from which to select notes:
List notes Beginning: 02/17/96// <Enter>  (FEB 17, 1996)
                Thru: 06/21/96// <Enter> (JUN 21, 1996)

1   06/21/96 11:40  Lipid Clinic                        Joe Ruell, MD
                    Visit: 02/21/96
2   06/21/96 11:38  Social Work Service                 Joe Ruell, MD
                    Visit: 04/18/96
3   06/07/96 00:00  Diabetes Education                  Doogey Howser, MD
                    Visit: 04/18/96
4   05/15/96 13:10  Addendum to Diabetes Education       STEVEN B. WINTER
                    Visit: 02/21/96
5   04/24/96 15:41  Lipid Clinic                         Joe Ruell, MD
                    Visit: 04/24/96
6   02/23/96 14:08  Diabetes Education                   Joe Ruell, MD
                    Visit: 02/21/96
Choose notes:  (1-6):3, 5
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME// <Enter>  VAX
```

Progress Notes Print Example

```
------------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                   Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 06/07/96 17:51    DIABETES EDUCATION
ADMITTED: 07/22/95 11:06 1A
SUBJECT: Routine diabetes education

Patient understanding good.

                  Signed by: /es/ Joe E. Ruell, MD
                                  Medical Internist 06/23/96 08:34
                                  Analog Pager:  555-1213
                                  Digital Pager: 555-1215
                Cosigned by: /es/ SELL,NOEL
                                   06/23/96 08:34
                                  Analog Pager: 555-1213
                                  Digital Pager:555-1215

NOTE DATED: 04/24/96 08:00    ARTERIAL EVALUATION - LOWER EXTREMITY
VISIT: 04/17/92 08:00 CARY'S CLINIC
SUBJECT: Rule out embolus, lower extremity

                AGE:  50
               UNIT:  General Medicine
       REFERRING MD:  Dr. Scholl
          DIAGNOSIS:  Rule out embolus

            HISTORY:  severe pedal edema, foot ulcers

              OTHER:  cyanosis
            SYMPTOMS:
   RESTING SYMPTOMS:
EXERTIONAL SYMPTOMS:
            LESIONS:
        MEDICATIONS:
RECORDED                              RECORDED
AUDIBLE DOPPLER SIGNAL    RIGHT   LEFT   DOPPLER WAVEFORM:    RIGHT  LEFT
  COMMON FEMORAL          _____   _____    COMMON FEMORAL     _____  _____

  SUPERFICIAL FEMORAL     _____   _____    PRE-EXERCISE       _____  _____
  POPLITEAL               _____   _____    POST-EXERCISE      _____  _____
  POSTERIOR TIBIAL        _____   _____    OTHER              _____  _____
  DORSALIS PEDIS          _____   _____

   N=NORMAL   ABN=ABNORMAL    O=ABSENT    B=BIPHASIC

TRANSCUTANEOUS PO2 VALUES:
                           RIGHT          LEFT
   SUBCLAVICULAR           ___40___       ___40___
   ABOVE KNEE              ___39___       ___40___
   HIGH BK                 ___39___       ___40___
   CALF                    ___37___       ___39___
   ANKLE                   ___36___       ___39___
   DORSUM OF FOOT          ___22___       ___38___
   OTHER                   ___18___       ___38___
Enter RETURN to continue or '^' to exit: <Enter>
```

Progress Notes Print Example cont'd

```
------------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                   Progress Notes
------------------------------------------------------------------------------
04/24/92 08:00       ** CONTINUED FROM PREVIOUS SCREEN **
   40      =ADEQUATE FOR HEALING
   39-30   =EQUIVOCAL FOR HEALING
   29-0    =INADEQUATE FOR HEALING

SEGMENTAL SYSTOLIC BLOOD PRESSURE:
                           RIGHT   INDEX          LEFT    INDEX
   ARM                     _______________        _______________
   HIGH THIGH              _______________        _______________
   ABOVE KNEE              _______________        _______________
   BELOW KNEE              _______________        _______________
   ANKLE  PT               _______________        _______________
   DP                      _______________        _______________


 EXERCISE RESPONSE:

       MPH:     5 mph


       MAXIMUM WALKING TIME:  _10_ MIN _30_ SEC

       SYMPTOMS: Pedal edema, cyanosis

       MAXIMUM HEART RATE ACHIEVED:

          TIME         RIGHT INDEX        LEFT INDEX         ARM

          1 MINUTE     _____________      _____________      _____________
          3 MINUTES    _____________      _____________      _____________
          5 MINUTES    _____________      _____________      _____________
         10 MINUTES    _____________      _____________      _____________
         15 MINUTES    _____________      _____________      _____________
         20 MINUTES    _____________      _____________      _____________

POST EXERCISE:

IMPRESSIONS:

                  Signed by: /es/ Joe E. Ruell, MD
                                  Medical Internist 04/24/96 14:19
                                  Analog Pager:  555-1213
                                  Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit: ^

   1      Discharge Summary Print
   2      Progress Note Print
   3      Clinical Document Print

Select Print Document Menu Option: <Enter>
```

Clinical Document Print

Use this option to print chart or work copies of all clinical documents available through TIU.

Steps to use option:

1. Select *Clinical Document Print* from the Print Document Menu, and then enter a patient name.

```
Select Print Document Menu Option: 3  Clinical Document Print
Select PATIENT NAME: DOE,WILLIAM C.       09-12-44     243236572     YES
SC VETERAN
            (2 notes)  C: 05/28/96 12:37
            (2 notes)  W: 05/28/96 12:33
                       A: Known allergies
            (2 notes)  D: 05/28/96 12:36

Available documents:  02/17/92 thru 06/21/96  (34)
```

2. Enter a date range that documents will be chosen from.

```
Please specify a date range from which to select documents:
List documents Beginning: 02/17/92// 6/1/96  (JUN 01, 1996)
                     Thru: 06/21/96// 6/8/96  (JUN 08, 1996)

1   06/07/96 00:00  Diabetes Education                  Doogey Howser, MD
                    Visit: 04/18/96
2   06/05/96 17:23  Lipid Clinic                        Joe Ruell, MD
                    Visit: 04/18/96
3   06/05/96 11:10  Addendum to Lipid Clinic           Joe Ruell, MD
                    Visit: 04/24/96
```

4. Choose the document or documents you would like printed, and whether you want work or chart copies.

```
Choose documents:  (1-3): 1-3
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME//  PRINTER
```

4. The document(s) will then be printed at the device you specify.

Search for Selected Documents

Use this option to generate a list of selected documents based on extended search criteria (e.g., status, search category, and reference date range).

Steps to use option:

1. Select *Search for Selected Documents* from the MIS Manager Menu.

2. Select the status of the documents you want to view (completed, unsigned, amended, etc.).

```
Select Text Integration Utilities (MIS Manager) Option:  Search for
Selected Documents

Select Status: COMPLETED// UNV   unverified
```

3. Select the type of documents you want to view (progress notes, discharge summary, etc.).

```
Select CLINICAL DOCUMENTS Type(s):  All Discharge Summary, Progress Notes,
Addendum
```

4. To make your search more specific, select one or more categories for the documents you want to view:

All Categories	Patient	Title
Author	Problem	Transcriptionist
Expected Cosigner	Service	Treating Specialty
Hospital Location	Subject	Visit

```
Select SEARCH CATEGORIES: AUTHOR// SERVICE
Select SERVICE: MEDICINE
```

5. To limit the search even further, specify a time period for the documents you want to view:

```
 Start Reference Date [Time]: T-7//T-30
Ending Reference Date [Time]: NOW// <Enter>
Searching for the documents....
```

6. After the documents are displayed, you can choose one of the actions listed below (amend, browse, delete, etc.) to perform on one or more of the documents.

```
UNVERIFIED Documents          Jun 09, 1997 10:11:11        Page:  1 of  1
                by ALL CATEGORIES from 04/10/97 to 06/09/97  4 documents
    Patient            Document                        Ref Date    Status
1 ANDERSON,H (A3456) Addendum to Discharge Summary 06/05/97 unverified
2 ANDERSON,H (A3456) Addendum to Discharge Summary 06/05/97 unverified
3 ANDERSON,H (A3456) Addendum to Discharge Summary 06/04/97 unverified
4+ ANDERSON,H(A3456) Discharge Summary             05/25/97 unverified




          + Next Screen  - Prev Screen  ?? More Actions             >>>
     Find                      Delete Document           Browse
     On Chart                  Reassign                  Print
     Edit                      Send Back                 Change View
     Verify/Unverify           Detailed Display          Quit
     Amend Document
Select Action: Quit// v=3   Verify/Unverify
```

```
Opening Addendum record for review...
Verify Document              Jun 09, 1997 10:11:46      Page:  1 of   33
                                  Addendum
ANDERSON,H C   321-12-3456   2B             Visit Date: 09/21/95@10:00

   DICT DATE: JUN 04, 1997            ENTRY DATE: JUN 05, 1997@16:10:02
 DICTATED BY: HOWSER,DOOGEY            ATTENDING: RUSS,JOE L.
     URGENCY: routine                     STATUS: UNVERIFIED


DIAGNOSIS:

1.  Status post head trauma with brain contusion.
2.  Status post cerebrovascular accident.
3.  End stage renal disease on hemodialysis.
4.  Coronary artery disease.
5.  Congestive heart failure.
6.  Hypertension.
7.  Non insulin dependent diabetes mellitus.
+         + Next Screen  - Prev Screen  ?? More actions
     Find                      Verify/Unverify
     Print                     Quit
Select Action: Next Screen// v   Verify/Unverify
Do you want to edit this Discharge Summary? NO// <Enter>
VERIFY this Discharge Summary? NO// y  YES
Discharge Summary VERIFIED.
Refreshing the list.
```

Correcting Documents that are Entered in Error

Reassigning signed documents is restricted to the "Chief, MIS User Class." This includes notes that are awaiting a co-signature. If the document is completely unsigned, users who are Author/Dictator or users with proper authorization may reassign it.

Besides reassigning a note to a different patient, admission, or visit, the reassign action may be used to promote an Addendum as an Original, swap the Addendum and the Original, change a discharge summary to an Addendum.

The basic reassign process includes the following steps:

1. **Electronic signature challenge.** If the document is already signed, TIU asks for the electronic signature of the Chief of MIS.
2. **Retract.** If the document is moved to a different patient, TIU retracts the document.
3. **Re-edit original visit.** If necessary, the PCE information is updated for the original visit.
4. **Edit destination visit.** If necessary, PCE information is collected or revised for the new visit.
5. **Sign.** The original provider needs to sign the document. If the document was moved to a different patient, TIU removes the original signature.

In the following example, an unsigned note is transferred from one patient to another:

```
Select OPTION NAME: TIU MAIN MENU MGR   Text Integration Utilities (MIS
Manager)

                          --- MIS Managers Menu ---

   1      Individual Patient Document
   2      Multiple Patient Documents
   3      Print Document Menu ...
   4      Search for Selected Documents
   5      Statistical Reports ...

Select Text Integration Utilities (MIS Manager) Option: 1  Individual
Patient Do
cument
Select PATIENT NAME: car
   1   CARLSON,MADISON        4-2-44    344568765     YES     NON-SERVICE
CONNEC
TED    THIS IS A TEST
   2   CARLSON,MARY        4-1-48    438090934     NO     NON-SERVICE
CONNECTED

CHOOSE 1-4: 2  CARLSON,MARY        4-1-48    438090934     NO     NON-
SERVICE CO
NNECTED    THIS IS A TEST
            (1 note )  C: 03/16/99 10:20

Available documents:  11/23/1998 thru 01/19/2001  (19)
```

Correcting Documents that are Entered in Error cont'd

```
Please specify a date range from which to select documents:
List documents Beginning: 11/23/1998// <Enter>  (NOV 23, 1998)
                  Thru: 01/19/2001// <Enter>  (JAN 19, 2001)
1   01/19/2001 10:27  Infection Control                    SNOW,C
                      Visit: 01/26/1999
2   12/30/2000 16:00  + Discharge Summary                  STRANDER,R
                        Adm: 12/25/2000  Dis: 12/30/2000
3   11/01/2000 14:00  Discharge Summary                    STRANDER,R
                        Adm: 04/19/2000  Dis: 11/01/2000
4   04/24/2000 00:00  Discharge Summary                    STRANDER,R

Choose one or more documents:  (1-4):1
```

```
Browse Document                Jan 19, 2001 10:33:50      Page:    1 of    1◄
                               Infection Control
CARLSON,M      438-09-0934   AUDIOLOGY AND SPE    Visit Date: 01/26/1999
17:50                                                                      ◄
DATE OF NOTE: JAN 19,2001@10:27:57   ENTRY DATE: JAN 19,2001@10:27:58
      AUTHOR: SNOW,CHARLES R       EXP COSIGNER:
     URGENCY:                           STATUS: UNSIGNED

Pt is very sick...
```

```
          + Next Screen  - Prev Screen  ?? More actions
     Find                      On Chart                  Reassign
     Print                     Amend                     Send Back
     Edit                      Delete                    Quit
     Verify/Unverify
Select Action: Quit// R   Reassign
```

```
Are you sure you want to REASSIGN this Infection Control? NO// Y  YES

Please choose the correct PATIENT and CARE EPISODE:

Select PATIENT NAME: jor
   1   JORDAN,AIR        *SENSITIVE*    *SENSITIVE*     NO     EMPLOYEE
THIS
IS A TEST
   2   JORDAN,MICHAEL        1-1-65    113344321     YES     SC VETERAN
THIS
IS A TEST
CHOOSE 1-2: 2  JORDAN,MICHAEL        1-1-65    113344321     YES     SC
VETERAN
   THIS IS A TEST

            (1 note )  W: 09/15/98 08:29
                       A: Known allergies
 Enrollment Priority: GROUP 1    Category: IN PROCESS    End Date:

This patient is not currently admitted to the facility...

Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT// <Enter>
```

```
The following SCHEDULED VISITS are available:

   1>  AUG 20, 1999@08:00                          JERRY CLINIC
   2>  JUL 30, 1999@09:00                          JERRY CLINIC
   3>  JUL 29, 1999@09:15                          JERRY CLINIC
   4>  JUN 03, 1999@13:00                          JERRY CLINIC
   5>  JUL 22, 1997@09:00  INPATIENT APPOINTMENT   SHIRL CLINIC
CHOOSE 1-5, or
<U>NSCHEDULED VISITS, <F>UTURE VISITS, or <N>EW VISIT
<RETURN> TO CONTINUE
OR '^' TO QUIT: 2  JUL 30 1999@09:00

Enter/Edit PROGRESS NOTE...
          Patient Location:  JERRY CLINIC
        Date/time of Visit:  07/30/99 09:00
         Date/time of Note:  01/19/01 10:27
            Author of Note:  SNOW,CHARLES R
   ...OK? YES//
AUTHOR/DICTATOR: SNOW,CHARLES R//

Infection Control Reassigned.

Press RETURN to continue...

Select PATIENT NAME:
```

Statistical Reports

Use this menu to produce statistical reports for line counts and timeliness by Author, Transcriptionist, or Service.

☞ NOTE: These reports are designed for a margin width of 132.

Option	Description
TRANSCRIPTIONIST Line Count Statistics	This option allows generation of statistical reports of line counts and timeliness data by transcriptionist (or the person who entered the document).
SERVICE Line Count Statistics	This option allows generation of statistical reports of line counts and timeliness data by SERVICE (e.g., Medical Service, Surgical Service, Psychiatry Service, etc.).
AUTHOR Line Count Statistics	This option allows generation of statistical reports of line counts and timeliness data by AUTHOR (or Dictating practitioner).

TRANSCRIPTIONIST Line Count Statistics

DISCHARGE SUMMARY Line Count Statistics by TRANSCRIPTIONIST JUN 27,1996 09:51
PAGE 1

Transcriber	Line Count	Ref Date	Patient	Disch-Dict	Dict-Transcr	Transcr-Sign	Sign-Cosign
BS	0	JUN 19,1996	SMITH,S		0		
Discharg							
	73	JUN 11,1996	ANDERSON,H C		1		
Discharg							
	78	MAY 31,1996	SMITH,S	7	1		
Discharg							
	72	MAR 25,1996	GRETSKI,D		1	0	
0	Discharg						
	78	MAR 24,1996	HOOD,R	-1	1	0	
0	Discharg						
	73	MAR 23,1996	NIVEK,A		1	0	
0	Discharg						
	73	FEB 12,1996	DOE,W C	84	2		
Discharg							
	80	FEB 8,1995	NIVEK,B		0	44	
0	Discharg						
	96	FEB 8,1995	NIVEK,E		0	44	
0	Discharg						
	---			---	---	---	

SUBTOTAL	623			90	7	88	
0							
SUBCOUNT	9			3	9	5	
5							
SUBMEAN	69.22			30.00	0.78	17.60	
DP	1	JAN 10,1996	HOOD,R	1004	0	0	
0	Discharg						
	---			---	---	---	

SUBTOTAL	1			1004	0	0	
0							
SUBCOUNT	1			1	1	1	
1							
SUBMEAN	1.00			1004.00			
SBW	0	MAY 25,1996	SMITH,J		1		
Discharg							
	---			---	---	---	

SUBTOTAL				0	1	0	
0							
SUBCOUNT	1			0	1	0	
0							
SUBMEAN					1.00		
jg	0	FEB 12,1996	DOE,W C	97	0		
Addendum							
	---			---	---	---	

SUBTOTAL				97	0	0	
0							
SUBCOUNT	1			1	1	0	
0							
SUBMEAN				97.00			
	---			---	---	---	

TOTAL	624			1191	8	88	
0							
COUNT	12			5	12	6	
6							
MEAN	52.00			238.20	0.67	14.67	
0.00							

Line Count Statistics by AUTHOR

DISCHARGE SUMMARY Line Count Statistics by AUTHOR JUN 27,1996 09:53
PAGE 1

Author	Line Count	Ref Date	Patient	Disch-Dict	Dict-Transcr	Transcr-Sign	Sign-Cosign
GRIN,J	0	FEB 12,1996	DOE,W C	97	0		
Addendum							
	---			---	---	---	---
SUBTOTAL				97	0	0	0
SUBCOUNT	1			1	1	0	0
SUBMEAN				97.00			
HOWSER,D	0	JUN 19,1996	SMITH,S		0		
Discharg							
	73	JUN 11,1996	ANDERSON,H C		1		
Discharg							
	78	MAY 31,1996	SMITH,S	7	1		
Discharg							
	72	MAR 25,1996	GRETSKI,D		1	0	0
Discharg							
	78	MAR 24,1996	HOOD,R	-1	1	0	0
Discharg							
	73	MAR 23,1996	NIVEK,A		1	0	0
Discharg							
	73	FEB 12,1996	DOE,W C	84	2		
Discharg							
	---			---	---	---	---
SUBTOTAL	447			90	7	0	0
SUBCOUNT	7			3	7	3	3
SUBMEAN	63.86			30.00	1.00		
MELDRUM,K	80	FEB 8,1995	NIVEK,B		0	44	0
Discharg							
	96	FEB 8,1995	NIVEK,E		0	44	0
Discharg							
	---			---	---	---	---
SUBTOTAL	176			0	0	88	0
SUBCOUNT	2			0	2	2	2
SUBMEAN	88.00					44.00	
PRICE,D	1	JAN 10,1996	HOOD,R	1004	0	0	0
Discharg							
	---			---	---	---	---
SUBTOTAL	1			1004	0	0	0
SUBCOUNT	1			1	1	1	1
SUBMEAN	1.00			1004.00			
WINTERTON,S B	0	MAY 25,1996	SMITH,J		1		
Discharg							
	---			---	---	---	---
SUBTOTAL				0	1	0	0
SUBCOUNT	1			0	1	0	0
SUBMEAN					1.00		
	---			---	---	---	---
TOTAL	624			1191	8	88	0
COUNT	12			5	12	6	6
MEAN	52.00			238.20	0.67	14.67	0.00

Line Count Statistics by SERVICE

DISCHARGE SUMMARY Line Count Statistics by SERVICE JUN 27,1996 09:42 PAGE 1

Service	Line Count	Ref Date	Patient	Disch-Dict	Dict-Transcr	Transcr-Sign	Sign-Cosign	
MEDICINE	0	JUN 19,1996	SMITH,S		0			Discharg
	73	JUN 11,1996	ANDERSON,H C		1			Discharg
	78	MAY 31,1996	SMITH,S	7	1			Discharg
	80	FEB 8,1995	NIVEK,B		0	44	0	Discharg
	96	FEB 8,1995	NIVEK,E		0	44	0	Discharg
SUBTOTAL	327			7	2	88	0	
SUBCOUNT	5			1	5	2	2	
SUBMEAN	65.40			7.00	0.40	44.00		
SURGERY	0	FEB 12,1996	DOE,W C	97	0			Addendum
	1	JAN 10,1996	HOOD,R	1004	0	0	0	Discharg
SUBTOTAL	1			1101	0	0	0	
SUBCOUNT	2			2	2	1	1	
SUBMEAN	0.50			550.50				
TOTAL	328			1108	2	88	0	
COUNT	7			3	7	3	3	
MEAN	46.86			369.33	0.29	29.33	0.00	

Chapter 6: TIU for Transcriptionists

- **Enter/Edit Discharge Summary**
- **Enter Document**
- **Upload Menu**

Chapter 6: TIU for Transcriptionists

Transcriptionists typically enter Providers' discharge summaries, progress notes, or other documents:

1) directly from dictation, or
2) from uploaded transcribed ASCII documents in batch mode
   - ♦ from remote microcomputers, using ASCII or KERMIT protocol upload, or
   - ♦ from Host Files (i.e., DOS or VMS ASCII files) on the host system.

   Options on this menu can be assigned accordingly.

Transcriptionist Menu

Option Name	Description
Enter/Edit Discharge Summary	This option lets you enter or edit discharge summaries and progress notes directly online. If the transcriptionist holds the AUTOVERIFY security key, each discharge summary will be verified automatically when the transcriptionist releases it.
Enter/Edit Document	This option lets you enter/edit clinical documents directly online.
Upload Menu ...	This menu includes options to upload batches of documents, and to get help on the header formats for the various documents which have been defined for upload by your site.

Enter/Edit Discharge Summary

Use this option to enter and edit discharge summaries directly online.

Steps to use option:

1. Select *Enter/Edit Discharge Summary* from the Transcriptionist Menu.

```
         --- Transcriptionist Menu ---

   1      Enter/Edit Discharge Summary
   2      Enter/Edit Document
   3      Upload Menu ...

You have PENDING ALERTS
          Enter  "VA   VIEW ALERTS     to review alerts

Select Text Integration Utilities (Transcriptionist) Option: 1
Enter/Edit Discharge Summary
```

2. Enter a patient's name and choose an Admission from the choices offered.

```
Select Patient: DOE,WILLIAM C. 09-12-44  243236572 YES   SC
VETERAN
For Patient DOE,WILLIAM C.
The following ADMISSION is available:
   1>  JUL 22, 1995@11:06     DIRECT                    TO:  1A
CHOOSE 1-1: 1  JUL 22 1991@11:06

 Patient: DOE, WILLIAM C         SSN: 243-23-6572     Sex: MALE
    Race: MEXICAN AMERICAN       Age: 52          Claim #: UNKNOWN
Adm Date: 12/22/96              Ward: 1A
Dis Date: 02/12/97
  Adm Dx: Stage IV non-Hodgkin's Lymphoma

Correct VISIT? YES// <Enter>

URGENCY: routine// <Enter>  routine
AUTHOR/DICTATOR: GREEN,JON        jg
DICTATION DATE: <Enter>  (FEB 12, 1997)
ATTENDING PHYSICIAN: GREEN,JON       jg
Calling text editor, please wait...
  1>DIAGNOSIS:
  2>
```

Enter/Edit Discharge Summary cont'd

The text editor brought up a boilerplate template used for Discharge Summaries; entries are added after the colons.

```
  3>
  4>
  5>
  6>OPERATIONS/PROCEDURES:
EDIT Option: 1
  1>DIAGNOSIS:
  Replace : With : Lymphoma  Replace
   DIAGNOSIS: Lymphoma
Edit line: 6
  6>OPERATIONS/PROCEDURES:
  Replace : With : Chemotherapy  Replace
   OPERATIONS/PROCEDURES: Chemotherapy
Edit line: <Enter>
EDIT Option: <Enter>
Save changes? YES// <Enter>

Saving Discharge Summary with changes...
Is this Discharge Summary ready to release from DRAFT? YES// n  NO
 NOT RELEASED.

You may enter another Discharge Summary. Press RETURN to exit.

Select PATIENT NAME: <Enter>
```

Enter/Edit Document

This option allows the transcriptionist to enter a new document (using a document title from the TIU document definition hierarchy) or to review, verify, send back to transcription, reassign, or print an existing document. The option produces a list of document definition types using search criteria such as status, search category, and reference date range, from which you select a document.

Steps to use option:

1. Select *Enter/Edit Document* from the Transcriptionist Menu.

```
Select Text Integration Utilities (Transcriptionist) Option: 2
Enter/Edit Document
Select AUTHOR: RUSS,JOE L.        JER
```

2. Enter a patient's name and choose the admission from the choices offered.

```
Select Patient:HOOD,ROBIN     04-25-31   603042591P   NO
MILITARY RETIREE
        (1 note )  C: 11/30/95 17:36
        (2 notes)  W: 09/16/96 15:12  (addendum 09/18/96 09:53)
                   A: Known allergies
        (1 note )  D: 11/30/95 17:38

For Patient HOOD,ROBIN
Select DOCUMENT TYPE: discharge summary          TITLE
The following ADMISSION(S) are available:
   1>  MAY 28, 1996@15:58     A/C                      TO:  1A
   2>  MAY 28, 1996@15:51     DIRECT                   TO:  1A
   3>  MAY 22, 1996@17:41     DIRECT                   TO:  1A
   4>  DEC 22, 1994@17:27     DIRECT                   TO:  1A
   5>  DEC 22, 1994@17:22     DIRECT                   TO:  2B
CHOOSE 1-5
<RETURN> TO CONTINUE
OR '^' TO QUIT: 1  MAY 28 1996@15:58

 Patient: HOOD, ROBIN              SSN: 603-04-2591P   Sex: MALE
    Race: AMERICAN INDIAN OR ALASKA NA  Age: 65   Claim #: UNKNOWN
Adm Date: 05/28/96                    Ward: 1A
  Adm Dx: TEST

Correct VISIT? YES// <Enter>
```

3. Enter the urgency (if routine, press Enter), author/ dictator, dictation date, and attending physician.

```
URGENCY: routine// <Enter>   routine
AUTHOR/DICTATOR:  RUSS,JOE        JER            GEEK
DICTATION DATE: 9/30  (SEP 30, 1996)
ATTENDING PHYSICIAN: howser,DOOGEY       DH            PGY2
RESIDENT
```

4. Your preferred editor appears (with boilerplate if any has been set up for this title) and you can now enter the text for this discharge summary.

```
Calling text editor, please wait...
  1>DIAGNOSIS:
  2>
  3>
  4>
  5>
  6>OPERATIONS/PROCEDURES:
EDIT Option: 2
  2>
  Replace <space>  With diabetes retinopathy  Replace
   diabetes retinopathy
Edit line: <Enter>
EDIT Option: <Enter>
Save changes? YES// <Enter>

Saving Discharge Summary with changes...
Is this Discharge Summary ready to release from DRAFT? YES//
<Enter>
Discharge Summary Released.
Chart copy queued.

You may enter another Discharge Summary. Press RETURN to exit.

Select PATIENT NAME: <Enter>
```

Upload Menu

The Upload Menu contains options that allow the transcriptionist to upload a batch of clinical documents.

Option Name	Description
Upload Documents	This option lets transcriptionists upload transcribed ASCII documents in batch mode, either from remote microcomputers, using ASCII or KERMIT protocol upload, or from Host Files (i.e., DOS or VMS ASCII files) on the host system. Your site may define the preferred file transfer protocol and the destination within **V*IST*A** to which each report type (e.g., discharge summary, progress notes, Operative Report, etc.) should be routed.
Help for Upload Utility	This option displays information on the formats of headers for dictated documents that are transcribed off-line and uploaded into **V*IST*A**. It also displays "blank" character, major delimiter, and end of message signal as defined by your site.

The upload utility permits mixed report types within a single batch. This allows the transcriptionist to enter each report in arrival sequence into a single ASCII file on the remote computer (e.g., using a proprietary word-processing program), and to transmit the text to the **V*IST*A** host system as a one-step process. As this ASCII data arrives at the **V*IST*A** host, it is read into a "buffer" file, and stored for subsequent "filing" by a special background process, called the "Router/filer."

The Router/filer is queued upon completion of transmission of a given batch of reports, and will proceed to "read" each line of the buffer file, looking for a header. When a header is encountered, the filer will determine whether the record corresponds to a known report type, as defined by your site, and if so, it will attempt to direct the record to the appropriate file and fields in **V*IST*A**.

On occasion, the Router/filer will not be able to identify the appropriate record in the target file, and will, therefore, be unable to file the record. When this happens, the process will leave the record in the buffer file and send an alert to the user who invoked the upload utility, and to a group of users identified by the site as being able to respond to such filing errors.

Upload Menu cont'd

When ***any*** of the alert recipients chooses to act on one of these alerts (by entering "VA" at any menu prompt, and choosing the alert on which they wish to act), they will be shown the header of the failed record, and allowed to inquire to the patient record, before being presented with their preferred **V*ISTA*** editor, and will then be allowed to edit the buffer (e.g., correct a bad social security number, admission date, etc.) and retry the filer. With each attempt to correct the buffered data and retry the filer, all alerts associated with that batch will be deleted (and if the condition remains uncorrected, re-sent), until all records in the batch are successfully filed.

Batch Upload Reports

Kermit Protocol Upload

If your site is using the upload option to transfer batches of discharge summaries from a remote computer using the Kermit transfer protocol, start the upload process by following the sequence below:

1. **Choose UP from your Upload Menu.**

```
   UP     Batch upload reports
   HLP    Display upload help

Select Upload menu Option: UP  Batch upload reports


                    K E R M I T   U P L O A D
Now start a KERMIT send from your system.
Starting KERMIT receive.
#N3
```

2. **When you see the #N3 prompt, initiate the Kermit file transfer from your computer.** Try the default settings for the Kermit protocol as provided by your terminal emulation software. If you have problems, consult your terminal emulator user manual or contact your local IRM Service.

3. **When the transfer is complete, you'll see this message:**

```
File transfer was successful.  (1515 bytes)
Filer/Router Queued!
Press RETURN to continue...<Enter>
   UP     Batch upload reports
   HLP    Display upload help
Select Upload menu Option:  <Enter>
```

ASCII Protocol Upload

If your site is using the upload option to transfer batches of discharge summaries from a remote computer using the ASCII transfer protocol, start the upload process by following the example shown below:

1. Choose UP from your Upload Menu.

```
   UP     Batch upload reports
   HLP    Display upload help

Select Upload menu Option: UP  Batch upload reports

                      A S C I I   U P L O A D
```

2. When the "Initiate upload procedure:" prompt appears, initiate the ASCII file transfer from your computer.

☞ NOTE: If you have problems, consult your local IRM Service to see if the Terminal and Protocol Set-up parameters have been set up as shown in the Implementation and Maintenance Section of the TIU Technical Manual, or check the user manual for your terminal emulator.

```
Initiate upload procedure:
$HDR:                                    DISCHARGE SUMMARY
>PATIENT NAME:                            DOE,JOHN A.
>SOC SEC NUMBER:                          555-12-1212
>ADMISSION DATE:                          02/20/93
>DISCHARGE DATE:                          02/25/93
>DICTATED BY:                             BENJAMIN P. CASEY, M.D.
>DICTATION DATE:                          02/26/93
>ATTENDING PHYSICIAN:                     MARCUS C. WELBY, M.D.
>TRANSCRIPTIONIST ID:                     T1212
>URGENCY:                                 PRIORITY
>DIAGNOSIS:
>1.  Acute pericarditis.
>2.  Status post transmetatarsal amputation, left foot.
>3.  Diabetes mellitus requiring insulin.
>4.  Diabetic neuropathy.
>
>Operations/Procedures performed during current admission:
>1.  Status post transmetatarsal amputation of left foot on
3/17/93.
>2.  Echocardiogram done 3/17/93.
                                    .
                                    .
                                    .
$END
Filer/Router Queued!

Press RETURN to continue...<Enter>
```

Handling upload errors

ASCII PROTOCOL UPLOAD / WITH ALERT:

```
   UP     Batch upload reports
   HLP    Display upload help

UPLOAD PROCESS (538972453) Failed: LOOKUP FAILED
          Enter  "VA   VIEW ALERTS     to review alerts
Select Upload menu Option: VA  View Alerts

 1.   UPLOAD PROCESS (538972453) Failed: LOOKUP FAILED
          Select from 1 to 1
          or Enter ?, A, I, P, M, R, or ^ to exit: 1

The header of the failed record looks like this:

$HDR: DISCHARGE SUMMARY
PATIENT NAME: DOE, WILLIAM C.
SOCIAL SECURITY NUMBER: 812-09-1244P
DATE OF ADMISSION: 11/17/95
DATE OF DISCHARGE:
DICTATED BY: DR GHOST
DICTATION DATE: 4/16/96
ATTENDING PHYSICIAN: JOE BLOW
TRANSCRIPTIONIST: C7689
URGENCY: PRIORITY
$TXT

Inquire to patient record? YES// <Enter>

Select PATIENT: DOE,WILLIAM C.   09-12-44     812091244P     SC
VETERAN
The following admissions are available:

   (dcs indicates a Discharge Summary exists)

         09-12-44     812091244P     SC VETERAN
   1        DOE,WILLIAM C.    Adm: 07/22/95    Dis: 10/28/92  Open
   2        DOE,WILLIAM C.    Adm: 10/28/95    Dis: 10/28/92  Open
   3        DOE,WILLIAM C.    Adm: 11/16/92    Dis:           Open
CHOOSE 1-3: 3

 Patient: DOE, WILLIAM C          SSN: 812-09-1244P     Sex: MALE
    Ward: 1A                      Race:                  Age: 48
Att Phys: KLARK,DICK              Prim Phys: KLARK,DICK
Adm Date: 11/16/95
  Adm Dx: ILL

Select PATIENT: <Enter>

You may now edit the buffered upload data.. . .
```

```
(Press PF1 then H for help)
==[ WRAP ]==[ INSERT  ]===========<  >============================
$HDR: DISCHARGE SUMMARY
PATIENT NAME: DOE, WILLIAM C.
SOCIAL SECURITY NUMBER: 812-09-1244P
DATE OF ADMISSION: 11/16/95    = Cursor to this point and change
the 7 to a 6, then
DATE OF DISCHARGE:                  Enter <PF1>E to exit and save
DICTATED BY: DR GHOST
DICTATION DATE: 4/16/96
ATTENDING PHYSICIAN: JOE BLOW
TRANSCRIPTIONIST: C7689
URGENCY: PRIORITY
$TXT
DIAGNOSES:
1. Status post coronary artery bypass graft.
2. Unstable angina prior to coronary artery bypass graft.
3. End stage renal disease.
4. Diabetes mellitus.
5. Hypertension.
6. History of peptic ulcer disease.
M=====T======T======T=======T=======T=======T=======T=======T====T

Now would you like to retry the filer? YES// <Enter>
Filer/Router Queued!

   UP     Batch upload reports
   HLP    Display upload help

Select Upload menu Option: <Enter>
```

In the example above, notice that patient John Doe had no admission on 11/17/96, so the filer could not create a record in the target file for this discharge summary record. The user acts on the alert to correct the admission date as 11/16/96, and retries the filer, which is now able to file the record appropriately, and the alerts are removed for all recipients.

Avoiding Upload Errors

TIU uses header information to file uploaded notes in the TIU Document File (#8925). Naturally, if this information is inaccurate, then either a filing error is generated or the note is filed incorrectly.

Note: Certain errors in the upload header can cause the upload routine to file the note incorrectly. This is a patient safety issue, so the accuracy of captions should be verified where possible.

Each type of document has a different set of upload captions and, in some cases, a different upload routine. Each routine tries to avoid incorrect filing of notes by cross-checking the patient information and dates with other information such as the consult number or surgery case number. Some types of documents have unique fields to assist the upload program in accomplishing these cross checks and/or to file the document.

A missing field error is generated either when a required field is missing, or a field does not match the example data given in the Upload Help Display (see **Display Upload Help** below).

The following table gives information on required fields and the cross-checks performed on fields for several document classes:

Type of Document	Caption	Use
PROGRESS NOTES	SSN	Required by filing routine
	VISIT/EVENT DATE	Required by filing routine. The patient record indicated by the SSN is checked for a matching visit or event.
	TITLE	Required by filing routine
	LOCATION	Required by filing routine
	AUTHOR	Generates missing field error
	DATE/TIME OF DICT	Generates missing field error
DISCHARGE SUMMARY	PATIENT SSN	Required by filing routine
	DATE OF ADMISSION	Required by filing routine. The patient record indicated by the SSN is checked for a matching admission date.
	DICTATED BY	Generates missing field error
	DICTATION DATE	Generates missing field error
	ATTENDING PHYSICIAN	Generates missing field error
	URGENCY	Generates missing field error

Type of Document	Caption	Use
CLINICAL PROCEDURES	SSN	Required by filing routine
	TITLE	Required by filing routine. This is the name of the procedure. The patient record indicated by the SSN is checked for a matching procedure.
	VISIT/EVENT DATE	Required by filing routine. The patient record indicated by the SSN is checked for a matching visit or event.
	CONSULT REQUEST NUMBER	Required by filing routine. The patient record indicated by the SSN is checked for a matching consult , that the consult is a clinical procedure, and that results are available for interpretation.
	TIU DOCUMENT NUMBER	Only required by filing routine when an incomplete CP document has been attached by the CPUser program. In this case, the consult request is checked for a matching TIU Document Number.
	DATE/TIME OF DICTATION	Required by filing routine
	LOCATION	Required by filing routine
	AUTHOR	Generates missing field error
CONSULTS	SSN	Required by filing routine
	TITLE	Required by filing routine
	CONSULT REQUEST NUMBER	Required by filing routine. The patient record indicated by the SSN is checked for a matching consult.
	VISIT/EVENT DATE	Required by filing routine. The patient record indicated by the SSN is checked for a matching visit.
	AUTHOR	Generates missing field error
	LOCATION	Required by filing routine
	DATE/TIME OF DICTATION	Generates missing field error

Type of Document	Caption	Use
PROCEDURE REPORT	PATIENT SSN	Required by filing routine
	DOCUMENT NUMBER	Required by filing routine. If missing, the upload routine infers it from the SSN and Operation Date (an optional field).
	SURGICAL CASE	Required by filing routine. If missing, the upload routine infers it from the SSN and Operation Date. Then, if there is more than one matching surgical case, it generates a missing field error.
	DICTATION DATE	Generates missing field error
	ATTENDING SURGEON	Generates missing field error
	DICTATED BY	Generates missing field error

Display Upload Help

Transcriptionists may select this option in the Upload Menu to display the formats expected by the upload process for the report types defined at your site.

The captioned headers may be captured as ASCII data and used to build macros using a commercial word-processors (e.g., WordPerfect or Microsoft Word), thereby avoiding having to retype the captioned headers, while minimizing the risk of spelling errors or inconsistencies with the formats expected by the host system.

```
   UP     Batch upload reports
   HLP    Display upload help

You have PENDING ALERTS
          Enter  "VA   VIEW ALERTS     to review alerts

Select Upload menu Option: HLP  Display upload help
Select REPORT TYPE: DISCHARGE SUMMARY// <Enter>  Discharge Summary

$HDR:                                    DISCHARGE SUMMARY
SOC SEC NUMBER:                          555-12-1212
ADMISSION DATE:                          02/21/96
DISCHARGE DATE:                          02/25/96
DICTATED BY:                             BENJAMIN P. CASEY, M.D.
DICTATION DATE:                          02/26/96
ATTENDING:                               MARCUS C. WELBY, M.D.
TRANSCRIPTIONIST ID:                     T1212
URGENCY:                                 PRIORITY
$TXT
  DISCHARGE SUMMARY Text
$END

*** File should be ASCII with width no greater than 80 columns.
*** Use "___" for "BLANKS" (word or phrase in dictation that isn't
understood).

Press RETURN to continue...<Enter>
```

Chapter 7: TIU for Remote Users

- **Individual Patient Document**
- **Multiple Patient Documents**

Chapter 7: TIU for Remote Users

The options on this menu allow remote users (e.g., VBA RO personnel) to access documents which have been completed (i.e., legally authenticated by signature or cosignature, if necessary), to facilitate processing of claims.

Remote User Menu

Option	Description
Individual Patient Document	This option allows remote users (e.g., VBA RO personnel) to access individual documents which have been completed.
Multiple Patient Documents	This option allows remote users (e.g., VBA RO personnel) to review and print multiple documents which have been completed

Individual Patient Document

Steps to use option:

1. Select *Individual Patient Document* from your TIU menu.

```
Select Integrated Document Management Option: Individual Patient Document
```

2. Select a patient.

```
Select PATIENT NAME: DOE,WILLIAM C.        09-12-44     243236572     YES
SC VETERAN
             (2 notes)  C: 05/28/96 12:37  (addendum 08/12/96 16:04)
             (2 notes)  W: 05/28/96 12:33
                        A: Known allergies
             (3 notes)  D: 07/08/96 14:14

Available documents:  02/17/92 thru 10/28/96  (54)
```

3. Enter a date range to display documents for.

```
Please specify a date range from which to select documents:
List documents Beginning: 02/17/96// <Enter>  (FEB 17, 1992)
                     Thru: 10/28/96// <Enter> (OCT 28, 1996)
                       Adm: 12/22/94
1  01/09/96 17:51  Diabetes Education          Stuart Dent, MS3
                       Adm: 07/22/91
    SUBJECT: Diet etc.
2  09/29/95 16:54  Lipid Clinic                Joe E. Ruell,
                       Adm: 08/14/95
    SUBJECT: Dyslipidosis
3  04/24/96 08:28  Lipid Clinic               Doogey Howser, MD
                     Visit: 04/24/92
    SUBJECT: Lipid test
4  02/17/96 08:00  Arterial Evaluation -       Joe E. Ruell,
                     Visit: 02/17/92
    SUBJECT: Rule out embolus, lower extremity   '^' TO STOP: 2
```

4. Choose a document from the list.

```
Choose documents:  (1-4): 1

Opening Diabetes Education record for review...
```

```
Browse Document          Jun 26, 1996 17:08:45    Page: 1 of   1
                        Diabetes Education
DOE,W C        243-23-6572            Visit Date: 01/09/96@17:06

DATE OF NOTE:JAN 09,1996@17:51:04  ENTRY DATE:JAN 09, 1996@17:51:04
      AUTHOR: DENT,STUART          EXP COSIGNER: RUELL,JOE
     URGENCY:                            STATUS: COMPLETED

Provided Mr. Doe with Diabetes diet pamphlet and explained areas he
especially needed to be concerned about.

/es/ Joe E. Ruell, MD
for Stuart Dent, MS3
Medical Student III

          + Next Screen  - Prev Screen  ?? More actions
     Find                       Print                    Quit

Select Action: Quit// Print
```

5. The document is printed at the device you specified.

```
------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                        Progress Notes
------------------------------------------------------------------
NOTE DATED: 01/09/96 17:51    DIABETES EDUCATION
ADMITTED: 07/22/91 11:06 1A
SUBJECT: Lipid TEST

Provided Mr. Doe with Diabetes diet pamphlet and explained areas he
especially needed to be concerned about.

                  Signed by: /es/ DENT,STUART, MD
                               Medical Student III 01/23/96 08:34
                                  Analog Pager:  1-900-976-8398
                                  Digital Pager: 1-900-976-7883
               Cosigned by: /es/ RUELL,JOEL
                                   01/23/96 08:34
                                  Analog Pager: 1-900-976-8398
                                  Digital Pager:1-900-976-7883
```

Multiple Patient Documents

Use this option to see a list of clinical documents for more than one patient in TIU. You can specify types, categories, and time range.

☞**Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone. The example below would probably be too broad in a large hospital.

Steps to use option:

1. Select *Multiple Patient Documents* from your TIU menu.

```
      --- Remote User Menu ---

   1      Individual Patient Document
   2      Multiple Patient Documents

Select Text Integration Utilities (Remote User) Option: 2  Multiple
Patient Documents
```

2. Enter a status.

```
Select Status: COMPLETED// all   undictated  untranscribed  unreleased
                                 unverified  unsigned  uncosigned
                                 completed amended  purged  deleted
```

3. Select a document type (such as Discharge Summary, Progress Notes, Addendum).

```
Select Clinical Documents Type(s): All Discharge Summary, Progress
Notes, Addendum
```

4. Select one of the following search categories

1	All Categories	5	Patient	9	Title
2	Author	6	Problem	10	Transcriptionist
3	Expected Cosigner	7	Service	11	Treating Specialty
4	Hospital Location	8	Subject	12	Visit

Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

```
Select SEARCH CATEGORIES: AUTHOR// all   All Categories
```

5. Enter a date range.

```
   Start Reference Date [Time]: T-7// <Enter>   (JUN 02, 1997)
   Ending Reference Date [Time]: NOW// <Enter>   (JUN 09, 1997@11:19)
Searching for the documents..
```

6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document to perform it on.

```
ALL Documents          Jun 09, 1997 11:20:01       Page:    1 of    1
          by ALL CATEGORIES from 06/02/97 to 06/09/97     14 documents
   Patient              Document                          Ref Date  Status
1  JONES,A  (J1965) ADVANCE DIRECTIVE                     06/06/97 completed
2  DRAGON,P (D1255) Addendum to CLINICAL WARNING          06/05/97 completed
3  RAMBO,J  (R1239) Adverse React/Allergy                 06/05/97 completed
4  RAMBO,J  (R1239) CRISIS NOTE                           06/05/97 completed
5  DRAGON,P (D1255) FANCY RAT NOTES                       06/04/97 completed
6  DRAGON,P (D1255) Addendum to Adverse React/Aller       06/04/97 completed
7  DRAGON,P (D1255) Addendum to Adverse React/Aller       06/04/97 completed
8  DOE,W C  (D6572) FANCY RAT NOTES                       06/04/97 completed
9  DRAGON,P (D1255) Addendum to Adverse React/Aller       06/03/97 completed
10 HOOD,R   (H2591) FANCY RAT NOTES                       06/03/97 completed
11 SMITH,S  (S1462) Addendum to FANCY RAT NOTES           06/03/97 completed
12 + SMITH,S(S1462) FANCY RAT NOTES                       06/03/97 completed
13 + HOOD,R (H2591) Discharge Summary                     06/02/97 completed
14 HOOD,R   (H2591) Addendum to Discharge Summary         06/02/97 unsigned

       + Next Screen  - Prev Screen  ?? More Actions                >>>
     Find                      Browse                    Change View
     Detailed Display          Print                     Quit
Select Action: Quit// P=13
DEVICE: HOME//   PRINTER
```

Multiple Patient Documents, cont'd

```
SALT LAKE CITY                          06/09/97 11:29       Page:  1
-------------------------------------------------------------------------
PATIENT NAME           | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
HOOD,ROBIN             |  66 |  M  | AMER | 603-04-2591P|
-------------------------------------------------------------------------
  ADM DATE   |  DISC DATE   | TYPE OF RELEASE   | INP | ABS | WARD NO
MAY 30, 1997 |              |                   |     |     |
-------------------------------------------------------------------------
DICTATION DATE: JUN 02, 1997        TRANSCRIPTION DATE: JUN 02, 1997
TRANSCRIPTIONIST: jg
DIAGNOSIS:
toe injury

OPERATIONS/PROCEDURES:
evaluated for prosthesis
C O P Y
SIGNATURE APPROVING PHYSICIAN/DENTIST
/es/ JOANN GREEN
                                          JON GREEN
                                          JON GREEN

JUN 02, 1997@16:55:56  ADDENDUM:
In remission.

                                SIGNATURE APPROVING PHYSICIAN/DENTIST


                                          Joel E. Russell, MS
```

Chapter 8: Progress Notes Print Options

- **Admission– Prints all PNs for Current Admission**
- **Author– Print Progress Notes**
- **Batch Print Outpt PNs by Division**
- **Location– Print Progress Notes**
- **Outpatient Location – Print Progress Notes**
- **Patient– Print Progress Notes**
- **Ward– Print Progress Notes**

Chapter 8: Progress Notes Print Options

Clinicians can print progress notes but most printing is geared towards MAS and managing this function on a medical center level.

TIU offers two methods of printing documents:

1. **Print actions on option screens**: Clinicians may print all types of documents using a variety of methods from the List Manager interface for TIU, including Progress Notes, Discharge Summaries, Consults, etc. Work and chart copies are possible. Chart copies are the recommended type of printed copy, but many sites still want to print work copies. For example, you may want to print work copies of unsigned notes.

   Other than the above List Manager printing, all other print options are on print menus. Only signed notes are available from these options.

2. **Progress Notes Print Menus**

   a. Progress Notes Print Menu
      For many types of users: clinical, administrative, management.

   b. MAS Options to Print Progress Notes
      For printing at the Wards and Clinics, both by individual patient and batch printing.

Progress Notes Print Menu

All of the options on this menu support the printing of chart or work copies.

☞**NOTE:** The location print option prints for any location that has signed notes entered for it, but it doesn't track anything.

Option	Description
Author– Print Progress Notes	This option produces chart or work copies of progress notes for an author, for a selected date range.
Location– Print Progress Notes	This option prints chart or work copies of progress notes for all patients who were at a specific location when the notes were written. The patients whose progress notes are printed on this report may not still be at that location. If Chart Copy is selected, each note will start on a new page.
Patient– Print Progress Notes	This option prints or displays progress notes for a selected patient by a selected date range.
Ward– Print Progress Notes	This option lets you print progress notes for all patients who are now on a ward for a selected date range. This option is only for ward locations. NOTE: Copies can only be printed to a printer, not to a computer screen.

MAS Options to Print Progress Notes

The MAS options are intended for printing at the Wards and Clinics, both by individual patient and batch printing.

Option	Description
Admission- Prints all PNs for Current Admission	This option prints all progress notes for a selected patient for the current admission if patient is an inpatient or LAST admission if the patient has been discharged.
Batch Print Outpt PNs by Division	This option batch prints outpatient progress notes in terminal digit order by division. Locations that the site would like excluded from this job may edit field #3 in file #8925.93. If the location is not entered in file #8925.93, it WILL be included.
Outpatient Location- Print Progress Notes	This option is designed to be used primarily by MAS. It produces CHARTABLE notes and tracks the last note printed for the selected outpatient location. Output is sorted in alphabetical order by patient.
Ward- Print Progress Notes	This option allows the printing of Progress Notes for ALL patients on the ward at the time the job is queued to print. All of the notes for a selected date range (regardless of the location of the note) will print. This option is only for WARD locations. NOTE: Copies can only be printed to a printer, not to a computer screen.

Author– Print Progress Notes Example

```
 ---Print Progress Notes---

   PNPA   Author- Print Progress Notes
   PNPL   Location- Print Progress Notes
   PNPT   Patient- Print Progress Notes
   PNPW   Ward- Print Progress Notes

Select Progress Notes Print Options Option: author- Print Progress Notes

                  Print Progress Notes for a Selected AUTHOR
------------------------------------------------------------------------------

AUTHOR:    RUELL,JOEL        JER            MD

Available notes: Aug 24, 1995 thru Oct 03, 1996
Print Notes Beginning: t-100  (MAY 01, 1996)
                 Thru: t-60   (JUL 10, 1996)

Searching for the notes........
>> 8 notes found for ruell,JOE
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME// PRINTER
```

```
------------------------------------------------------------------------------
ANDERSON,H C  321-12-3456                                      Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 05/08/96 11:01    DIABETES EDUCATION
ADMITTED: 04/21/96 10:00 2B

------------------------------------------------------------------------------
SUBJECTIVE:    45 year old AMERICAN INDIAN here for
               initial evaluation of his DYSLIPIDEMIA.
               COPIED FROM HOOD TO ANDERSON...
PMH:

               Significant negative medical history pertinent to the
               evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION
HISTORY:       CURRENT MEDICATIONS

DIET:          Counseled on AHA Step I diet today by Araceli Neal.
               See her evaluation.
ACTIVITY:

OBJECTIVE:     HT:  70 (08/23/95 11:45)   WT:  207 (08/23/95 11:45)
               TSH/T4: 1.7/1.1
                  FBG: 200           HEMOGLOBIN A1C: 15.2
                SGOT: 44               URIC ACID: 4.7
Enter RETURN to continue or '^' to exit: <Enter>
```

Author– Print Progress Notes Example cont'd

```
------------------------------------------------------------------------------
ANDERSON,H C  321-12-3456                                    Progress Notes
------------------------------------------------------------------------------
06/05/96 15:18       ** CONTINUED FROM PREVIOUS SCREEN **

ASSESSMENT:    1.      MALE with / without documented CAD
               2.      CV Risk factors:
               3.      Lipid pattern:
PLAN:          1.      Implement recommendations to lower fat intake.
               2.      Repeat FBG and HBG A1C on:
               3.      Return to review lab on:

                  Signed by: /es/  Joe Ruell, MS
                                   Physician Assistant 06/21/96 07:47
                                   Analog Pager:  555-1213
                                   Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit:<Enter>

------------------------------------------------------------------------------
ANDERSON,H C  321-12-3456                                    Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 06/21/96 11:38    SOCIAL WORK SERVICE
ADMITTED: 06/01/96 10:00 2B
Follow-up to 6/1/96 visit.

                  Signed by: /es/ Joe E. Ruell, MS
                                   Physician Assistant 06/21/96 07:47
                                   Analog Pager:  555-1213
                                   Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit:<Enter>

------------------------------------------------------------------------------
HOOD,ROBIN  603-04-2591P                                     Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 07/03/96 14:18    LIPID CLINIC
ADMITTED: 05/28/96 15:58 1A
SUBJECTIVE:    65 year old AMERICAN INDIAN OR ALASKA NATIVE MALE here for
               initial evaluation of his DYSLIPIDEMIA.
               MORE STUFF...
PMH:

               Significant negative medical history pertinent to the
               evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION
HISTORY:       CURRENT MEDICATIONS

DIET:          Counseled on AHA Step I diet today by Araceli Neal.

ACTIVITY:
```

Author – Print Progress Notes Example cont'd

```
OBJECTIVE:     HT:  70 (08/23/95 11:45)   WT:  178 (07/01/96 17:15)
               TSH/T4: 1.7/1.1
                  FBG: 223           HEMOGLOBIN A1C: 15.2
                SGOT: 44               URIC ACID: 4.7

ASSESSMENT:    1.      MALE with / without documented CAD
               2.      CV Risk factors:
               3.      Lipid pattern:

PLAN:          1.      Implement recommendations to lower fat intake.
               2.      Repeat FBG and HBG A1C on:
               3.      Return to review lab on:

                  Signed by: /es/  Joe Ruell, MS
                                   Physician Assistant 07/03/96 14:19
                                   Analog Pager:  1-900-976-8398
                                   Digital Pager: 1-900-976-7883

Enter RETURN to continue or '^' to exit: ^
AUTHOR: <Enter>
```

Location – Print Progress Notes Example

```
Select Progress Notes Print Options Option: Location- Print Progress Notes

                  Print Progress Notes for a Selected LOCATION
------------------------------------------------------------------------------

Select HOSPITAL LOCATION NAME: GENERAL MEDICINE        PERSON,CURT

Available notes: Sep 06, 1995 thru Oct 02, 1996
Print Notes Beginning: t-30  (SEP 08, 1996)
                 Thru: t  (OCT 08, 1996)

Searching for the notes..
>> 2 notes found for GENERAL MEDICINE
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME// <Enter>  VAX
```

```
------------------------------------------------------------------------------
DOE,WILLIAM C.  243-23-6572                                  Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 10/01/96 11:59    BP TEST
VISIT: 04/18/96 10:00 GENERAL MEDICINE
     NAME: DOE,WILLIAM C.
      SEX: MALE
      DOB: SEP 12,1944

ALLERGIES: Amoxicillin, Aspirin, MILK

     LABS: No data available

   LIPIDS: No data available

       HT: 72 (08/23/95 11:45)
       WT: 190 (08/23/95 11:45)

                  Signed by: /es/ Joe E. Ruell, MS
                                  10/01/96 15:38
                                  Analog Pager:  1-900-976-8398
                                  Digital Pager: 1-900-976-7883

Enter RETURN to continue or '^' to exit: <Enter>

------------------------------------------------------------------------------
HOOD,ROBIN  603-04-2591P                                     Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 09/17/96 13:37    LIPID CLINIC
VISIT: 08/18/96 08:00 GENERAL MEDICINE
SUBJECTIVE:    55 year old AMERICAN INDIAN OR ALASKA NATIVE MALE here for
               initial evaluation of his DYSLIPIDEMIA.

PMH:
               Significant negative medical history pertinent to the
               evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:
MEDICATION
HISTORY:       CURRENT MEDICATIONS
DIET:          Counseled on AHA Step I diet today by Araceli Neal.

Enter RETURN to continue or '^' to exit: <Enter>
```

Location – Print Progress Notes Example cont'd

```
------------------------------------------------------------------------------
HOOD,ROBIN  603-04-2591P                                      Progress Notes
------------------------------------------------------------------------------
09/17/96 13:37       ** CONTINUED FROM PREVIOUS SCREEN **

ACTIVITY:

OBJECTIVE:     HT:  70 (08/23/96 11:45)   WT:  207 (08/23/96 11:45)

               TSH/T4: 1.7/1.1

                  FBG: 200           HEMOGLOBIN A1C: 15.2

                SGOT: 44               URIC ACID: 4.7

ASSESSMENT:    1.      MALE with / without documented CAD
               2.      CV Risk factors:
               3.      Lipid pattern:

PLAN:          1.      Implement recommendations to lower fat intake.
               2.      Repeat FBG and HBG A1C on:
               3.      Return to review lab on:

                  Signed by: /es/ Joe E. Ruell, MD
                                  10/02/96 10:34
                                  Analog Pager:  1-900-976-8398
                                  Digital Pager: 1-900-976-7883


Enter RETURN to continue or '^' to exit: ^

Select HOSPITAL LOCATION NAME: ^
```

Patient– Print Progress Notes Example

```
Select Progress Notes Print Options Option: p Patient-Print Progress
Notes
                  Print Progress Notes for a Selected PATIENT
---------------------------------------------------------------------
Select PATIENT NAME:OUTPATIENT,EDNA   04-01-44   234776641     YES
   SC VETERAN
            (1 note )  W: 09/02/95 09:00

Available notes: Sep 06, 1995 thru Mar 21, 1996
Print Notes Beginning: t-360  (APR 08, 1995)
                 Thru: t  (APR 02, 1996)
Searching for the notes.....
>> 5 notes found for OUTPATIENT,EDNA
Do you want WORK copies or CHART copies? CHART// <Enter>
Do you want to start each note on a new page? NO//<Enter>
DEVICE: HOME// <Enter>  LAT TERMINALS
```

```
---------------------------------------------------------------------
OUTPATIENT,EDNA  234-77-6641                          Progress Notes
---------------------------------------------------------------------
NOTE DATED: 09/01/95 12:00    General Note
VISIT:                 CARDIOLOGY

This is a very sad situation.  It is also a general progress
note.  We hope the patient does better in the future.
She is quite nice, clean and nice.

                  Signed by: /es/ TAN DEFAN
                                  VERIFIER 09/06/95 21:51

NOTE DATED: 09/02/95 09:00    Clinical Warning
VISIT:                 CARDIOLOGY

Beware: this patient bites.

                  Signed by: /es/ TAN DEFAN
                                  VERIFIER 09/06/95 21:53

NOTE DATED: 11/08/95 15:20    History & Physical Ex
VISIT: 09/05/95 11:00 DIABETES CLINIC
SUBJECT: TESTING THE GLUCOSE LEVEL

1. Chief Complaint: Numbness in legs
   Reason for Admission (if different from #1)

2. History of Present Illness: Type 2 onset 1993

   Medication Allergies: Penicillin causes rash

   Current Medications: Oral insulin
Enter RETURN to continue or '^' to exit: <Enter>
```

Patient– Print Progress Notes Example cont'd

```
------------------------------------------------------------------
OUTPATIENT,EDNA  234-77-6641                        Progress Notes
------------------------------------------------------------------
11/08/95 15:20       ** CONTINUED FROM PREVIOUS SCREEN **

3. PAST HISTORY
   1. Hospitalizations: 6/10/93
      Surgeries:                                    Injuries:
      Illness:                                  Disabilities:
      Transfusion(s): ( )Yes (X)No
                      If Yes, give date(s):

   2. Unusual Childhood Illnesses:
      Immunizations:
      (X)DT last booster: 1/90    ( )Pneumonia            ( )Flu
      ( )Hep B                    ( )Other:

   3. Habits:   (x)Smoking        (x)Alcohol              ( )Drugs
      Caffeine Use: (x)Coffee     ( )Tea                  ( )Cola
      ( )Suicide Attempts         ( )OTHER:

4. SOCIAL/MILITARY HISTORY (Occupations):
      ( )WWI   ( )WWII    ( )KOREAN    (x)VIETNAM    ( )GULF WAR

      Travel:                          Lives with:

      Source of Income: ( )Job ( )Retired  (x)Pension  ( )Other

5. REVIEW OF SYSTEMS:

6. PHYSICAL:
   1. Ht. HEIGHT     Wt. WEIGHT        Temp.   Resp.
      BP:  Lying:         Sitting:              Standing:

   2. General:  (x)Well  ( )Obese  ( )Thin ( )Malnourished ( )Neat
                ( )Chronically Ill    ( )Toxic  ( )Acute Distress
   3. Head:

   4. Eyes:

ENT:

Enter RETURN to continue or '^' to exit: <Enter>
```

Patient– Print Progress Notes Example cont'd

```
------------------------------------------------------------------
OUTPATIENT,EDNA  234-77-6641                        Progress Notes
------------------------------------------------------------------
11/08/95 15:20       ** CONTINUED FROM PREVIOUS SCREEN **

   6. Neck:

   7. Chest and Breasts:

   8. Lungs:

   9. Lymphatics (Cervical, Epitrocholear, Axillary, Inguinal,
Popliteal):
  10. Heart:

  11. Abdomen:

  12. Pelvic/Genitalia (Penis, Scrotum, Testicles):

  13. Rectal:

  14. Neurological:
      Cranial Nerves:
      Peripheral Neurological exam:

      Reflexes: 0 - No reflex                 _
                1 - Hyporeflexia             ( )
                2 - Average                   _l_
                3 - Brisk                  \/  l  \/
                4 - Hypereflexia             ___l___
                                            /       \
                                            l       l
                                           _l       l_
  15. Musculoskeletal:
      Upper Extremities:
      Lower Extremities:
      Spine:
  16. Psychiatric:
      a. Are any cognitive impairments noted?         ( )Yes  ( )No
      b. Are any communication impairments noted?     ( )Yes  ( )No

  17. Skin:

7. WOMEN'S GYNECOLOGICAL HISTORY AND PHYSICAL EXAM

   HISTORY:
   Menarche:     ( )Yes  ( )None  Interval/Duration:
   Characteristics:
Enter RETURN to continue or '^' to exit: <Enter>
```

Patient– Print Progress Notes Example cont'd

```
------------------------------------------------------------------
OUTPATIENT,EDNA  234-77-6641                        Progress Notes
------------------------------------------------------------------
11/08/95 15:20       ** CONTINUED FROM PREVIOUS SCREEN **
   Last Pap:      Results:        Previous Gyn Surgery:
   Birth Control Method:          Number of Pregnancies:
   Miscarriages:
   Stillbirths:   Live Births:    Menopause Onset:   What effect:

   Hormones:                      Prior STD History:

   Last Mammogram:                Results:

   Number of sexual partners in the past six months?
        Y       N          SYMPTOMS                DESCRIPTION
       ( )     ( )  Stress Incontinence
       ( )     ( )  Vaginal Discharge/Itching
       ( )     ( )  Rash/Sores
       ( )     ( )  Lower Abdominal Pain
       ( )     ( )  Dyspareunia
       ( )     ( )  Breast Lumps/Pain
       ( )     ( )  Breast Rash/Nipple Discharge
       ( )     ( )  Abnormal Bleeding
       ( )     ( )  Other:

   PHYSICAL EXAMINATION:
NOTE: Ohio State Law requires that every female inpatient receive a
breast and pelvic exam unless one was performed within the preceding
12 months or the patient refuses the examination in writing. (Patient
must sign below).
   BREASTS:               l  l
DESCRIPTION/QUADRANT
                        ______l  l______
                      / /              \  \
                     l  l   l     l   l  l
                     l  l --o-- --o-- l  l
                     l  l   l     l   l  l

   GENITALIA (Vulva, Urethra, Vagina, Cervix, Fundus, Adnexa)
 PATIENT REFUSAL OF EXAMINATION
[ ] I do not wish to receive a breast or pelvic exam at this time.
[ ] I would like to be scheduled for an outpatient breast and pelvic
exam at the Women's Health Clinic.

   Patient's Signature:_____________________________________
8. INITIAL IMPRESSION/ASSESSMENT:
9. WORKING DIAGNOSIS:
10. PLAN:
Enter RETURN to continue or '^' to exit: <Enter>
```

Patient– Print Progress Notes Example, cont'd

```
------------------------------------------------------------------
OUTPATIENT,EDNA  234-77-6641                        Progress Notes
------------------------------------------------------------------
11/08/95 15:20       ** CONTINUED FROM PREVIOUS SCREEN **

NOTE DATED: 03/20/96 08:30    Diabetes Education - Glucose Monitoring
VISIT: 03/19/96 08:00 DIABETES EDUCATION
SUBJECT: TESTING MULTIPLE COPY

Date of Class:
Class:    Advantage Blood Glucose Monitor
Process:  Lecture, Demonstration, and Return Demonstration
Issued:  Advantage monitor, Level I and II glucose control solutions,
and 3 boxes (50 each) Advantage test strips.

Subjective:  Patient states:
___________Tests his BG________times/day
___________Has not received previous directions.

Objective:
Patient attended class.  With Significant Other?  No    Yes
Any observed barriers to learning?   No    Yes

Concepts:
1.  Location of batteries.
2.  Using memory.
3.  Coding machine.
4.  Using glucose control. These expire 3 mo after opening.
5.  Performing a blood glucose test.
  A.  Clean fingertip (only) with warm soap and water.
  B. Use side of any or all fingertips unless there is sore or
other damage present.
6.  Proper care and storage of machine and strips.
7.  Disposal of lancets in puncture-proof container.  Label.
A:  Knowledge deficit r/t Advantage SBGM
P:  If no previous directions received, recommend 1-2 X day test and
prn any signs low blood sugar.
RX:
1.  Advantage glucose monitor kit (To pharmacy)
2.  Advantage glucose control solutions. Disp 1 box Q 3 mo.  Refill
X3. (To pharmacy).
3.___No__Advantage Test Strips.Disp:__0___Boxes Q 3 mo. Refill X3.
  ___No____Monojector.  Only one.  No Refill.
  ___No______Lancets.  #100 Q 3 mo.  Refill X3.
Evidence of Learning:  Patient  coded, used glucose controls,
and checked his own blood sugar during class.  When mistakes were
made, they were acknowledged by patient and corrective action stated.
                  Signed by: /es/ DOOGEY HOWSER
                             PGY3 MEDICAL RESIDENT 03/20/96 08:31
```

Ward– Print Progress Notes Example

This option is usually used by the night ward clerk. The output is in RM/BED order to facilitate filing. It prints all notes after the last time they were printed, and for ALL current inpatients on the ward, regardless of whether the location of the note is that ward, a nice feature for transferred patients or patients with outpatient clinic appointment notes. **This print option requires that you specify a printer; you can't print to the screen.**

Print by Ward is designed to support batch printing. It has the unique ability to determine when the last note was printed so that sites can now capture the infamous "orphan" note which was a problem under Progress Notes 2.5. A new page is started for each patient.

```
                Print Progress Notes for ALL patients on WARD
------------------------------------------------------------------------

Select WARD Location: 6  1A

Print Notes Starting With (DATE/TIME): t-20  (MAY 23, 1997).........
...........
>> 32 notes found for WARD 1A

DEVICE: PRINTER
```

```
========================================================================
MEDICAL RECORD                                            Progress Notes
========================================================================
NOTE DATED: 05/27/97  12:13  CLINICAL WARNING
ADMITTED: 04/20/97  15:58  1A

Mr. Hood is becoming violent and self-destructive again. Will try a new
Prescription.

                                  Signed by:/ es/ Joe E. Brown, MD
                                  05/27/97  12:14



05/28/98  09:45      Addendum
Mr. Hood is more calm, and responding to counseling and medication

                                  Signed by:/ es/ Joe E. Brown, MD
                                  05/28/97  10:14

NOTE DATED: 04/20/97  12:13  CLINICAL WARNING
ADMITTED: 04/20/97  15:58  1A

Mr. Hood is violent and self-destructive again. Prescribed tranquilizer.

                                  Signed by:/ es/ Joe E. Brown, MD
                                  04/20/97  01:20

HOOD,ROBIN                REGION 5                Printed: 06/09/97  11:50
```

Section 3: Managing TIU

Chapter 9: Managing TIU: Introduction

TIU is managed through use of the following tools:

- Menu assignments
- Parameter set-ups
- Document Definitions
- User Class set-up

See the *TIU Implementation Guide* for more detailed instructions on performing these various set-ups.

TIU Maintenance Menu

Option Name	Menu Text	Description
TIU PARAMETERS MENU	TIU Parameters Menu	This option allows the Clinical Coordinator or IRMS Application Specialist to set up either the Basic or Upload Parameters for TIU
TIUF DOCUMENT DEFINITION	Document Definitions	Document Definitions menu, which includes: Edit Document Definitions Sort Document Definitions Create Document Definitions Create Objects
USR CLASS MANAGEMENT MENU	User Class Management	Menu of options for managing User Class Definition and Membership

Legal Requirements

Patient Confidentiality

TIU works with patient records and documents. All users are reminded to be aware of the confidentiality of these records.

Electronic Signature

TIU uses a combination of menu access, User Classes, and Electronic Signature codes to maintain security and responsibility. Individuals in the system who have authority to approve actions, at whatever level, have an **electronic signature code**. Like the access and verify codes used when gaining access to the system, the electronic signature code is not visible on the screen. These codes are also encrypted so that they are unreadable to other users, even when viewed in the user file by those with the highest levels of access. Electronic signature codes are required by TIU for every action that currently requires a signature on paper.

How to Change Your Electronic Signature Code

1. Select User's Toolbox from the Mailman Menu.
2. Select Edit Electronic Signature Code from the User's Toolbox menu.

```
Select Option: User's Toolbox
    Display User Characteristics
    Edit Electronic Signature code
    Edit User Characteristics Menu Templates ...
    Spooler Menu ...
    TaskMan User
    User Help

Select User's Toolbox Option: Edit Electronic Signature code
This option is designed to permit you to enter or change your Initials, Signature
Block Information and Office Phone number. In addition, you are permitted to enter a
new Electronic Signature Code or to change an existing code.
```

3. Enter your initials.
4. At the "Signature Block Printed Name:" prompt, enter your name as you want it printed on forms that require your signature.
5. At the "Signature Block Title: prompt," enter your job title as you want it printed on forms that require your signature.
6. Enter your office phone number.
7. Enter your signature code.

Electronic Signature, cont'd

```
INITIAL: JG
SIGNATURE BLOCK PRINTED NAME: JO GRIN
SIGNATURE BLOCK TITLE: Clinical Coordinator
OFFICE PHONE: (801)427-3736
Enter your Signature Code:xxxxxxx
```

Cosignature

Cosignature requirements are determined at local levels. Sites or departments can set Cosignature requirements for certain kinds of documents through the *Document Parameter Edit* option on the TIU Parameters Menu. Individual clinicians can designate a default cosigner on their Personal Preferences option.

Links and Relationships with Other Packages

TIU is closely linked to other applications and utilities — Authorization/Subscription Utility (ASU) List Manager utility, the Computerized Patient Record System (CPRS), Visit Tracking, etc. This linkage should remain transparent to users, but the IRM Service and Clinical Coordinators will need to coordinate the components.

Instructions will be provided (with a TIU patch) for setting up the interface with CPRS.

See the User and Technical Manuals of the above-listed packages for further instructions about interfaces.

Chapter 10: Menus and Option Assignment

TIU menus and options are not exported on a single menu, but as individual menus intended for categories of users. These are described in earlier sections of this manual and also here. Sites may rearrange these as needed. Recommended assignments are also listed on the following pages. We've also included an example of a potential Clinical Coordinator Menu.

```
Progress Notes(s)/Discharge Summary [TIU] ...
      1       Progress Notes User Menu ...
              1       Entry of Progress Note
              2       Review Progress Notes by Patient
              2b      Review Progress Notes
              3       All MY UNSIGNED Progress Notes
              4       Show Progress Notes Across Patients
              5       Progress Notes Print Options…
              6       List Notes By Title
              7       Search by Patient AND Title
              8       Personal Preferences…
      2       Discharge Summary User Menu ...
              1       Individual Patient Discharge Summary
              2       All MY UNSIGNED Discharge Summaries
              3       Multiple Patient Discharge Summaries
      3       Integrated Document Management
              1       Individual Patient Document
              2       All MY UNSIGNED Documents
              3       Multiple Patient Documents
              4       Enter/edit Document
      4       Personal Preferences ...
              1       Personal Preferences
              2       Document List Management
```

```
Text Integration Utilities (MRT) ...
     1       Individual Patient Document
     2       Multiple Patient Documents
     3       Review Upload Filing Events
     4       Print Document Menu ...
             1       Discharge Summary Print
             2       Progress Note Print
             3       Clinical Document Print
     5       Released/Unverified Report
     6       Search for Selected Documents
```

```
Text Integration Utilities (MIS Manager) ...
     1       Individual Patient Document
     2       Multiple Patient Documents
     3       Print Document Menu ...
             1       Discharge Summary Print
             2       Progress Note Print
             3       Clinical Document Print
     4       Search for Selected Documents
     5       Statistical Reports...
```

```
Text Integration Utilities (Transcriptionist) ...
     1      Enter/Edit Discharge Summary
     2      Enter/Edit Document
     3      Upload Menu...
            1      Upload Documents
            2      Help for Upload Utility
```

```
   Text Integration Utilities (Remote User) ...
          1      Individual Patient Document
          2      Multiple Patient Documents
```

```
   Progress Notes Print Options ...
          PNPA    Author- Print Progress Notes
          PNPL    Location- Print Progress Notes
          PNPT    Patient- Print Progress Notes
          PNPW    Ward- Print Progress Notes
```

```
   Document Definitions (Clinician) ...
          1      Edit Document Definitions
          2      Sort Document Definitions
          3      View Objects
```

```
    MAS Options to Print Progress Notes...
         Admission- Prints all PNs for Current Admission
         Batch Print Outpt PNs by Division
         Outpatient Location- Print Progress Notes
         Ward- Print Progress Notes
```

```
   TIU Maintenance Menu...
   1     TIU Parameters Menu...
             1      Basic TIU Parameters
             2      Modify Upload Parameters
             3      Document Parameter Edit
             4      Progress Notes Batch Print Locations
             5      Division - Progress Notes Print Params
   2     Document Definitions (Manager) ...
             1      Edit Document Definitions
             2      Sort Document Definitions/Objects
             3      Create Document Definitions
   3     User Class Management ...
             1      User Class Definition
             2      List Membership by User
             3      List Membership by Class
             4      Edit Business Rules
             5      Manage Business Rules
```

TIU Conversion Clean-up Menu [GMRP TIU]

This menu comes with Patch GMRP*2.5*44 which is distributed prior to TIU to help clean up the Generic Progress Notes File (#121) and the Generic Progress Notes Title File (121.2). It also contains options to assist in populating the TIU Document Definition File (8925.1), which is roughly equivalent to file #121.2.

This menu is NOT exported on any existing menu. It should be assigned to the person responsible for getting the Progress Notes package ready for conversion to TIU. We suggest that this be limited to one person per site or several people working closely together on these clean-up exercises.

```
1  Calculate Number of PNs per TITLE
2  Number of Notes per TITLE - Report
3  DELETE a Progress Notes TITLE
4  MOVE Notes to Another TITLE
5  Edit TITLE - Enter/Edit Doc Class
6  TITLEs Sorted by Document Class - Report
7  CONVERT TITLEs (#121.2) to TIU (#8925.1)
PRT  Title of Progress Note
UN   List Unsigned Progress Notes by AUTHOR
DEL  Delete a Signed Progress Note
```

Suggested Clinical Coordinator Menu

TIU doesn't export a Clinical Coordinator Menu. However, sites may wish to create one which includes most of the other menus and options, except possibly IRM options requiring programmer access.

```
   Text Integration Utilities (Transcriptionist) ...
   Text Integration Utilities (MRT) ...
   Progress Notes(s)/Discharge Summary [TIU] ...
   Text Integration Utilities (MIS Manager) ...
   Text Integration Utilities (Remote User) ...
   Progress Notes Print Options ...
   MAS Options to Print Progress Notes…
   Document Definitions  ...
   TIU Parameters Menu...
   User Class Management ...
   Upload Menu
```

Menu Assignment

We recommend assigning menus as follows:

Option Name	Menu Text	Description	Assign to:
TIU MAIN MENU TRANSCRIP-TION	Text Integration Utilities (Transcriptionist)	Main Text Integration Utilities menu for transcriptionists.	Transcrip-tionists
TIU MAIN MENU MRT	Text Integration Utilities (MRT)	Main Text Integration Utilities menu for Medical Records Technicians.	Medical Records Technicians
TIU MAIN MENU MGR	Text Integration Utilities (MIS Manager)	Main Text Integration Utilities menu for MIS Managers.	MIS Managers.
TIU MAIN MENU CLINICIAN	Progress Notes(s)/ Discharge Summary [TIU]	Main Text Integration Utilities menu for Clinicians.	Clinicians
TIU MAIN MENU REMOTE USER	Text Integration Utilities (Remote User)	This option allows remote users (e.g., VBA RO personnel) to access only those documents that have been completed, to facilitate processing of claims on a need-to-know basis.	VBA RO personnel, etc.
TIU PRINT PN USER MENU	Progress Notes Print Options	Menu for printing Progress Notes.	ADPACs, managers
TIU MAS PRINT PN MENU	MAS Options to Print Progress Notes	Menu of options for printing Progress Notes for specific locations, individually or by batch	MAS ADPACs & supervisors
TIUF DOCUMENT DEFINITION	Document Definitions	Document Definition (Clinician) Document Definition (Manager)	Clinicians Clinical Coordinator, IRM staff
TIU IRM MAINTENANCE MENU	IRM Maintenance Menu	This option allows IRM staff to set/modify the various parameters controlling the behavior of TIU, as well as the definition of TIU documents.	IRM, maybe Clinical Coordinators (or some of the options on the menu.
GMRP TIU	TIU Conversion Clean-up Menu	A menu of options for getting the Progress Notes package ready for conversion to TIU	ADPACs, IRM, or Clinical Coordinators. Limit to few.

Chapter 11: Setting up TIU Parameters

TIU Parameters Menu

This menu contains options for Clinical Coordinators or IRM Application Specialists to set up the basic parameters (including Upload parameters) for TIU.

Menu Text	Option Name	Description
Basic TIU Parameters	TIU BASIC PARAMETER EDIT	This option allows you to enter the basic or general parameters which govern the behavior of the Text Integration Utilities
Modify Upload Parameters	TIU DOCUMENT PARAMETER EDIT	This option allows the definition and modification of parameters for the batch upload of documents into **V*IST*A**.
Document Parameter Edit	TIU UPLOAD PARAMETER EDIT	This option lets you enter the parameters that apply to specific documents (i.e., Titles), or groups of documents (i.e., Classes, or Document Classes).
Division - Progress Notes Print Params	TIU PRINT PN DIV PARAM	These parameters are used by the [TIU PRINT PN BATCH INTERACTIVE] and [TIU PRINT PN BATCH SCHEDULED] options. If the site desires a header other than what is returned by $$SITE^ VASITE the .02 field of the 1st entry in this file will be used. For example, Waco-Temple-Marlin can have the institution of their progress notes as "CENTRAL TEXAS HCF."
Progress Notes Batch Print Locations	TIU PRINT PN LOC PARAMS	Option for entering hospital locations used for [TIU PRINT PN OUTPT LOC] and [TIU PRINT PN WARD] options. If locations are not entered in this file they will not be selectable from these options.

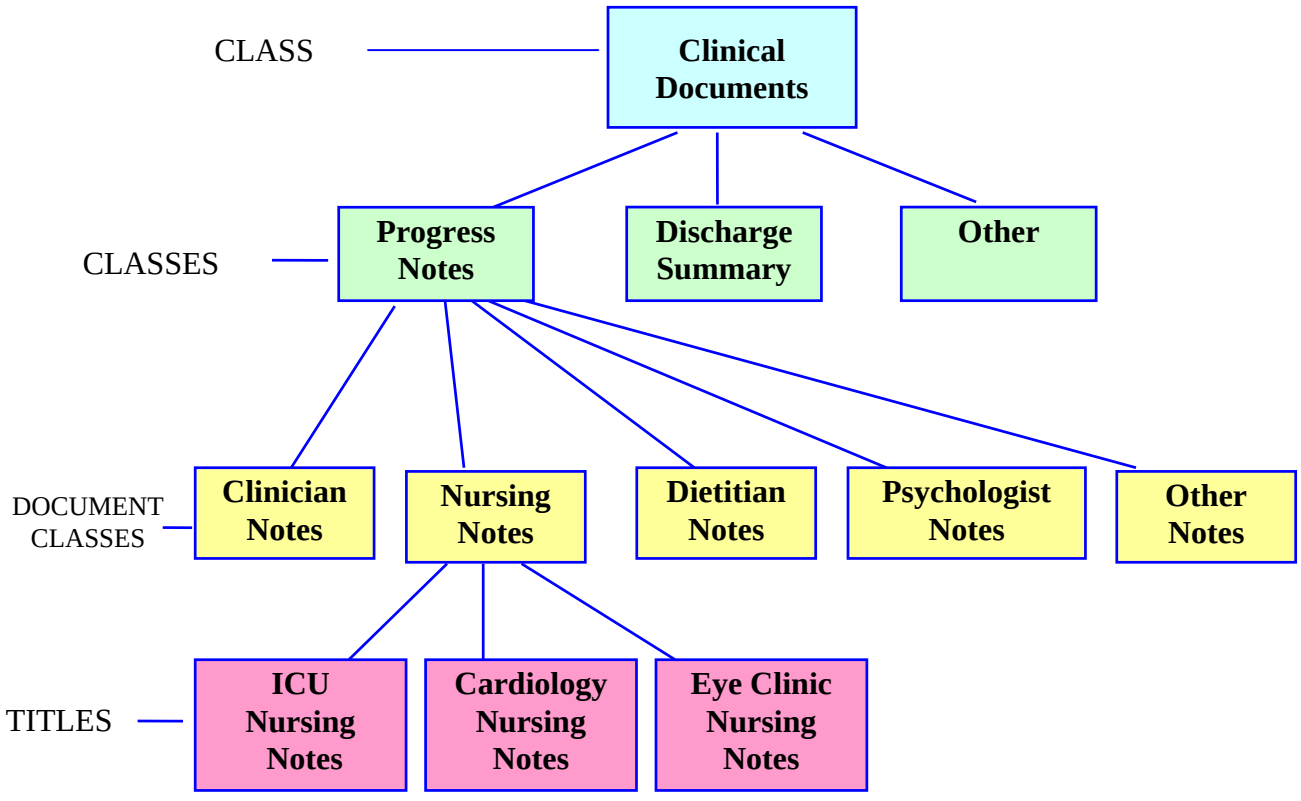
☞ **NOTE:** The *TIU Implementation Guide* and *TIU Technical Manual* contain instructions and examples for using these options.

Chapter 12: Document Definitions

TIU uses a document storage database called the Document Definition hierarchy. This hierarchy provides the building blocks for Text Integration Utilities (TIU). It allows documents (Titles) to inherit characteristics of the higher levels, Class and Document Class, such as signature requirements and print characteristics. This structure, while complex to set up, creates the capability for better integration, shared use of boilerplate text, components, and objects, and a more manageable organization of documents. End users (clinical, administrative, and MIS staff) need not be aware of the hierarchy. They work at the Title level with the actual documents.

Plan the Document Definition Hierarchy your site or service will use before installation of TIU and conversion of progress notes. This step is critical to the organization of existing and future documents in each site's implementation of TIU. A worksheet is provided in Appendix A of the *TIU Implementation Guide* to help build the three basic levels.

Example of Document Definition Hierarchy



Document Definition Options

Option Text	Option Name	Description
Edit Document Definitions	TIUFH EDIT DDEFS	This option lets you view and edit entries. Entries are presented in hierarchy order. Items of an entry are in sequence order, or if they have no sequence, in alphabetic order by menu text, and are indented below the entry. Since Objects don't belong to the hierarchy, they can't be viewed/edited using the Edit Options.
Create Document Definitions	TIUFC CREATE DDEFS	This option lets you create new entries of any type (Class, Document Class, Title, Component) except Object, placing them where they belong in the hierarchy. Although entries can be created using the Edit and Sort options, the Create option streamlines the process. This option presents entries in hierarchy order, traversing ONE line of descent, starting with Clinical Documents at the top. The Create option permits you to view, edit, and create entries, but only from within the current line of descent. The Create Option doesn't let you copy an entry.
Sort Document Definitions	TIUFA SORT DDEFS	This option lets you view parts of the hierarchy by selected sort criteria. It displays the selected entries in alphabetic order by Name, rather than in hierarchy order. Depending on sort criteria, entries can include Objects. The Sort option lets you view and edit entries.
Create Objects	TIUFJ CREATE OBJECTS MGR	This option lets you create new objects or edit existing objects. First you select Start With and Go To values, and the existing Objects within those values are displayed in alphabetical order.
View Objects	TIUFJ VIEW OBJECTS MGR	This option lets you look at or edit existing objects. First you select Start With and Go To values, and the existing Objects within those values are displayed in alphabetical order.

☞ **NOTE:** For further information about using the Document Definition system, see the *TIU/ASU Implementation Guide* or the *TIU Technical Manual.*

Chapter 13: Defining User Classes

The Authorization/Subscription Utility (ASU), which is distributed with TIU, provides a mechanism for sites to associate users with User Classes, allowing them to specify the level of authorization needed to sign or order specific document types and orderables. It also allows privileges to be inherited, through its use of a hierarchical structure. A set of Business Rules (which can be modified or added to by sites) further strengthens the Utility's ability to define roles and responsibilities for clinical documents.

See the *ASU Clinical Coordinator Manual* or the *TIU/ASU Implementation Guide* for more information about ASU, its relationship to TIU, and its implementation.

User Class Management Menu

Option	Option Name	Description
User Class Definition	USR CLASS DEFINITION	This option allows review, addition, editing, and removal of User Classes.
List Membership by User	USR LIST MEMBERSHIP BY USER	This option allows review, addition, editing, and removal of individual members to and from User Classes.
List Membership by Class	USR LIST MEMBERSHIP BY CLASS	This option allows review, addition, editing, and removal of individual members to and from User Classes.
Edit Business Rules	USR EDIT BUSINESS RULES	This option allows the user to enter Business Rules authorizing specific users or groups of users to perform specified actions on documents in particular statuses (e.g., an UNSIGNED PROGRESS NOTE may be EDITED by a PROVIDER who is also the EXPECTED SIGNER of the note, etc.).
Manage Business Rules	USR BUSINESS RULE MANAGEMENT	This option allows you to list the Business rules defined by ASU, and to add, edit, or delete them, as appropriate.

Chapter 14: Helpful Hints/Troubleshooting

FAQs (Frequently Asked Questions)

☞ **NOTE:** *Most of these questions were received from TIU/ASU test sites. Thanks to everyone who contributed!*

Q: We just entered all of our Providers into the Person Class file (when the Ambulatory Care Reporting Project came out). Do we have to do this all over again for the User Class file in ASU? Why can't TIU and ASU just use the Person Class?

A: The Provider Class in ASU fulfills a different function, and therefore its database design is a different kind of hierarchy.

A patch to ASU in the near future will help assure that your efforts in populating the Person Class Membership at your site are not lost, or repeated. We are developing a mapping between a subset of the exported User Classes and the Person Class File (i.e., for each Person Class, there will be a corresponding User Class), which will help you "autopopulate" User Class Membership, assure that future changes to an individual's Person Class Membership are reflected automatically in his User Class Membership, and allow resolution of privileges for inter-facility access to data. We recommend that you initially implement TIU and ASU by populating only the most essential User Classes (i.e., Provider; MRT; Chief, MIS; and Transcriptionist), and use the forthcoming patch to assist you in autopopulating more specific User Classes when you have become acquainted with the two products.

Q: We've heard that implementation of TIU is *very* complex and time-consuming. How long *does* is take?

A: TIU implementation *is* complex, but the amount of time it takes to implement has to do with the complexity of the site—how many users; how big the database is; how extensive the hierarchy is; the level of users; how dependent the site is on the package (obviously a site that is totally electronic has very different issues than a site where participation is optional. It took a test site with a million+ notes about 2.5 weeks to run their Progress Notes conversion.

FAQs cont'd

Q: Will the Discharge Summary and Progress Notes packages be gone once files are converted to TIU?

A: Discharge Summary V. 1.0 and Progress Notes V. 2.5 should be made "Out of Order" once the conversions have been run, staff trained, and the cut-over started. The data in files 121 and 128 will remain until your site decides to purge these files. We suggest that they remain intact until you're sure the conversions have run correctly and the implementation is going smoothly.

Q: Can TIU be used without converting the Discharge Summaries until much later?

A: TIU *can* be used without converting Discharge Summary, but we strongly recommend that Progress Notes and Discharge Summary both be converted to TIU at the same time, to avoid complications.

☞ **NOTE:** You cannot run dual implementations of Discharge Summary; that is, Discharge Summary 1.0 and Discharge Summary through TIU.

Q: Is it possible to load ASU in production and start populating the groups before we load TIU?

A: Yes you can. The Business Rules will not be functional because they are tied to the Document Definition File, but you will be able to populate the Class memberships.

Q: Do we have to delete or sign unsigned notes before we can convert them?

A: No, you don't have to delete or sign the unsigned notes. The conversion will move them as is. However, you probably don't want to be moving old, irrelevant notes from one package to the other. By the way, notes for test patients are NOT moved; they are ignored.

FAQs cont'd

Q: Can we require a Cosignature for a particular note?

A. Yes, you can set Cosignature requirements for document classes or titles. Use the option *Document Parameter Edit*, as described in the *TIU Implementation Guide*. Individual clinicians can designate an expected Cosigner through their *Personal Preferences* option (described on page 64 of this manual).

Q Why do we have to enter Visits and encounter data for Progress Notes? What are "Historical Visits"?

A: Visit data is now required for every outpatient encounter. The vast majority of Progress Notes are already linked to an admission and don't require additional visit information to be added.

A historical visit or encounter is a visit that occurred at some time in the past or at some other location (possibly non-VA). Although these are not used for workload credit, they can be used for setting up the PCE reminder maintenance system, or for other non-workload-related reasons.

☞ **NOTE:** If month or day aren't known, historical encounters will appear on encounter screens or reports with zeroes for the missing dates; for example, 01/00/95 or 00/00/94.

Q: Are there any terminal settings that we need to be aware of for TIU? On the VT400 setting in Smart Term, the bottom half of the Create Document Definitions screen was not scrolling properly. It was writing over previous lines and got very confusing!

A: Various terminal emulators can affect applications using the List Manager interface. The VT220 and 320 work very well with List Manager.

FAQs cont'd

Q: I have gotten my 600 clinic and ward locations set up, but when I try to print by ward I am only allowed to print to a printer. This is not true under the Print by Hospital Location, where I can print to the screen. What is the difference?

A: Print by Ward is designed to support batch printing. It has the unique ability to determine when the last note was printed so that sites can now capture the infamous "orphan" note which was a problem under Progress Notes 2.5. You might consider adding a message on entry into the option to inform users that they can only print to a printer (not on screen).

Q: Can we share business rules with other sites.

A: It isn't yet known how appropriate or desirable it is to share business rules amongst sites. The package is exported with all the business rules needed to run the standard package. The differences are usually on a medical center basis.

For example, one site wants all users to be able to see all UNSIGNED notes. ON the flip side, another site doesn't want any users to be able to print or view UNCOSIGNED notes until the cosigner has signed. Two very different views. Just because you are in the same VISN doesn't mean you would view these issues in the same light. Another example is the hospital that wants to restrict the entering/viewing/ printing of every Progress Note by TITLE. You can do this, but it is not something we would recommend.

We strongly recommend that you work with the exported business rules for awhile before making any changes.

Q: When I read my Discharge Summaries after they come back from the transcriptionist, there are dashes (or other funny characters) sprinkled throughout; what do these mean and what am I supposed to do?

A: These characters (your site determines whether they will be dashes, hyphens or some other character) indicate words or phrases that the transcriptionist was unable to understand. You need to replace these with the intended word or phrase before you'll be able to sign the document.

Q: What is the best editing/word-processing program and how can I learn how to use it?

A: This is partly a matter of personal preference and partly a matter of what's available at your site. Commercial word-processors are available at some sites. The FileMan line editor and Screen Editor are available at all sites. Of these two, most Discharge Summary users prefer the Screen Editor. Your IRM office or ADPACs can help you get set up with the appropriate editor and provide training. The Clinician Quick Reference Card summarizes the FileMan Screen Editor functions.

Q: Why should a site require "release from transcription"?

A: Release from transcription is required to prevent a discharge summary from becoming visible to other users before the person entering the summary has completed the entry. For example, if a transcriptionist needed to leave the terminal, the summary would not be available for anyone else to look at until the summary is "released from transcription."

Q: Why can't we use extended ASCII characters (e.g., °, ≥, Δ, etc.) in our documents to be uploaded?

A: These alternate character sets are not standardized across operating systems and your MUMPS system may not be set up to store them.

Questions about Reports and Upload

Q: At present we put all discharges in the Discharge Summary package. We do allow Spinal Cord Injury to put "interim" summaries in on their patients every 6 months or annually. These reports stack up under the admission date and are all under that one date upon discharge.

When patients are transferred to the Intensive Care Units, they may have a very long/complicated summary to describe the care while in the unit. This should be an interward transfer note, but some of our physicians feel that due to the complexity of care delivered in the unit, this should be included in their Discharge Summary, BUT should have its own date (episode of care). I realize that the interward transfer note is a progress note and very few of our physicians are using progress notes. Our physicians seem to want to have that interward transfer information in these complex cases attached to the Discharge Summary.

My question is will TIU offer us anything different that will satisfy our physicians? I still do not have a mental picture of what it will look like when I go to look up a DCS or PN from the TIU package. Will the documents be intermingled and arranged by date? I am a firm believer in calling things what they are and putting them where they belong when it comes to organizing our electronic record. I hate to see the DSC and interward transfers go together now in the DCS package as it does create a problem when the patient is actually discharged and Incomplete Record Tracking (IRT) thinks he was discharged when the interim was written. Does anyone have any thoughts and can someone show me how it looks when I get TIU and look up documents on a patient?

A: From: Joel Russell, TIU Developer

Interim Summaries may be easily defined in TIU, and linked with the corresponding IRT deficiency. Parameters determining their processing requirements, as well as the format of a header for uploading them in mixed batches with Discharge Summaries, Operative Reports, C&P exams, and Progress Notes can all be defined without modifying any code. A patch will be necessary to link them to a specific transfer movement, and to introduce a chart copy of the appropriate Standard Form. This involves a modest programming effort, but will have to be prioritized along with a number of other requests.

We need the help of the user community to try to sort out the relative priorities of each of these tasks, along with your patience, as we work to deliver as many of them as possible, as timely as possible...

A: From a user/coordinator:

A possible solution to the problem of rotating residents is to set up your summary package with the author not needing to sign the summary. This allows the attending physician to sign the report. While the residents may rotate in and out, the attending usually remains the same through the course of the patients stay.

Q. What are sites doing with C&Ps, & op notes?

It is my understanding that C&Ps are a type of discharge summary.

I've tried creating "C&P EXAM" as a title underneath the "DISCHARGE SUMMARY" document class. I get TYPE errors when uploading test documents. The document parameters are defined for the upload fields.

A: *From a user/coordinator:* OP reports and C&P exams reside in their appropriate packages. You can use the TIU upload utility to put them there.

As for OP notes, we have several titles (i.e. Surgeon's Post-OP note).

Do you have TIU in the APPLICATION GROUP field of the Surgery and C&P file?

Our FILE File has this for our Surgery file:

```
NUMBER: 130                    NAME: SURGERY
APPLICATION GROUP: GMRD
APPLICATION GROUP: TIU
```

Q: Can we do batch upload of Progress Notes by vendor through TIU?

A: Yes, you may now batch upload Progress Notes through TIU. See instructions earlier in this manual (under Setting Parameters) or in the TIU Technical Manual.

Q: Currently our Radiology reports are uploaded by the vendor. Can this functionality be built into TIU?

A: You may upload Radiology Reports, but it will be necessary to write a LOOKUP METHOD to store several identifying fields in the Radiology Patient File. The remainder are stored in the Radiology Reports File, along with the Impression and Report Text. (The TIU and Radiology development teams will work together on a lookup method, as development priorities allow.)

Q: We have hundreds of entries in files 128.1 and 128.5 to be cleaned up, because many duplicate discharge summaries were mistakenly uploaded by the transcriptionists of our vendor. How can we clean up these files?

A: You can use the *Individual Patient Document* option on the GMRD MAIN MENU MGR menu, along with VA FileMan, to clean up the Discharge Summary files.

Questions about Document Definition (Classes, Document Classes, Titles, Boilerplate text, Objects)

Q: After the initial document definition hierarchy is built and used, can we modify the hierarchy structure if we feel it is incorrectly built? How flexible is this file?

A: Once entries in the hierarchy are in use, you can't move them around. It would be wise to think your hierarchy through before installation. Don't rush the process. If necessary, create new classes, document classes, and titles (the Copy function streamlines creating new titles), and deactivate the old ones. The users won't be aware of the change if the Print Name is the same, but the .01 Name is new.

FAQs cont'd

Q: Who creates titles and boilerplates at a site?

A: Many test sites restrict the creation of titles and boilerplates as much as possible. At one site, users submit a request for a title or boilerplate. IRMS or the clinical coordinator create the boilerplate and/or title and forward it to the Chairman of the Medical Records Committee for approval. Once approved it is made available for use. Titles are name-spaced by service and the use of titles is restricted by user class. With the ability to search by title, keeping the number of titles small and their use specific can be very useful;.e.g. patient medication education is documented on an electronic progress note and can be reviewed easily.

Some of the other sites allow the ADPACs to create boilerplates without going through such a formal review process. Another site restricts this function to the Clinical Coordinator. It was designed so that sites can do whatever they are most comfortable with.

Q: The root Class supplied with the package is CLINICAL DOCUMENTS. Can a peer class level be made using our configuration options? Ex: ADMINISTRATIVE DOCUMENTS

A: You cannot enter a class on the same level as Clinical Documents. In TIU Version 1.0, entries can only be created under Clinical Documents.

Q: I've changed the technical and print names for a Document Class, but it doesn't seem to have changed when I select documents across patients. What am I doing wrong?

A: When you select documents across patients, you are presented with a three-column menu. The entries in this menu are from the Menu Text subfield of the Item Multiple. To make a consistent change, you must update Menu Text as well as Print Name when you change a Document Definition name.

Q: How can I print when I'm in Document Definitions options?

A: All Document Definitions printing is done using the hidden actions Print Screen and Print List. First, locate the data to be printed so that it shows on the screen and then select either the action PS or PL. To locate the appropriate data use the Edit, Sort, or Create option to list appropriate entries.

To print a list, select the PS or PL action at this point. To print information on a single given entry, first locate the entry in one of the above lists, then select either the Detailed Display action or the Edit Items action. Edit View shows all available information for a given entry. Edit Items shows the items of a given entry. Then select PS or PL. Enter PS for Print Screen to print the current display screen. It *only* prints what is currently visible on the screen, ignoring information that can be moved to horizontally or vertically (pages), so you should move left/right and up/down to the desired information before printing.

Enter PL for Print List to print more than one visible screen of information. Print List prints the entire vertical list of entries and information, including entries and information not currently visible but which are displayed when you move up or down. If the action is selected from the leftmost position of the screen, you're asked whether to print ALL columns or only those columns visible on the current leftmost position of the screen. If you select the action after scrolling to the right, only the currently visible left/right columns are printed.

Q: Is it possible for sites to share objects they create locally?

A: As sites develop their own Objects, they can be shared with other sites through a mailbox entitled TIU OBJECTS in SHOP,ALL (reached via FORUM).

☞**NOTE:** Object routines used from SHOP,ALL are ***not*** supported by the CIO Field Offices (formerly known as ISCs or IRMFOs). Use at your own risk!

Helpful Hints/Troubleshooting, cont'd

Q: Is there any way to change the Title of a Progress Note? For example, if I want to change one of my CWAD notes to a Nursing Psychology note, is that possible?

A: Yes. Use the "hidden" action Change Title.

Q: Is there a way to access progress notes that have been linked to a problem? I can't seem to find how this is done.

A: Assuming that notes are being linked to problems, you can use the *Show Progress Notes Across Patients* option to search for notes by Problem. When prompted to Select SEARCH CATEGORIES:, enter Problem.

```
Select Progress Notes User Menu Option:  Show Progress Notes Across
Patients

Select Status: COMPLETED// ALL   undictated  untranscribed  unreleased
unverified  unsigned  uncosigned completed,  amended  purged  deleted
Select Progress Notes Type(s): ALL Advance Directive, Adv React/Allergy  Crisis
Note  Clinical Warning  Historical Titles

Select SEARCH CATEGORIES: AUTHOR// PROB   Problem
Select PROBLEM: ANGINA PECTORIS, UNS
2 matches found
1   Angina pectoris, unstable
2   Other and unspecified angina pectoris
 Type "^" to STOP or Select 1-2:  1
Start Reference Date [Time]: T-2// T-9999  (JAN 20, 1970)
Ending Reference Date [Time]: NOW// <Enter>   (JUN 06,1997@09:00))
Searching for the documents.
```

Of course, this query has several limitations:

1 Only one problem may be selected at a time (i.e., you can't select ANGINA PECTORIS OR AIHD as a search criterion)
2 Problems can't be "grouped" or expressed ambiguously (e.g., a search for ANGINA PECTORIS, rather than ANGINA PECTORIS, UNSTABLE, would not have found this record), and
3 The only way for this benefit to be exercised at all is for the clinicians at your facility to be actively using Problem List.

Still, if you're interested in a focused search for all notes about a specific problem, and if your facility has committed to the use of the Problem List package, this can be a powerful asset for retrospective research, utilization review, and epidemiological studies. With the Preventive Measures for certain chronic diseases being made part of the Director's performance appraisal, being able to easily pull notes that document what was done for those problems is of HIGH importance.

Facts & Helpful information

Action abbreviations on List Manager screens

The TIU and ASU packages don't use mnemonics (abbreviations or numbers) for actions (protocols) on List Manager screens, partly because it's difficult to make them consistent with other packages and what users expect. Sites, however, can feel free to add whatever their users would like to have (e.g., $ for Sign).

Shortcuts

- At any "Select Action" prompt, you can type the action abbreviation, then the = sign and the entry number (e.g., E=4).
- Jump to Document Def in the Edit Document Definition option takes you directly to a document definition (Class, Document Class, or Title) if you know the name.
- When reviewing several notes, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

Visit Information

When you enter a Progress Note for an outpatient, this Progress Note now needs to be associated with a "visit." For the majority of Progress Notes, this visit association is done in the background, based on Scheduling or Encounter Form data. If a visit has already been recorded for the date your Progress Note refers to, but the Progress Notes wasn't linked (e.g., for standalone visits such as telephone or walk-in visits), you can select a visit from the choices presented to you during the PN dialogue. If no visit has been recorded, you must create a new visit. See the example below.

Example: Entry of Progress Note which needs Visit Information

```
Select PATIENT NAME: BABBIT, G  BABBITT,GEORGE F        4-9-46  448668829
YES     SC VETERAN
           (7 notes)  D: 07/11/00 08:41
                      A: Known allergies

Enter RETURN to continue or '^' to exit: <Enter>

 Enrollment Priority: GROUP 3    Category: IN PROCESS    End Date:


Available notes:  11/25/1998 thru 07/13/2000  (71)
Do you wish to see any of these notes? NO// <Enter>
TITLE: ADVERSE  11/12 ADVERSE REACTION/ALLERGY     TITLE
```

Example: Entry of Progress Note, cont'd

```
This patient is not currently admitted to the facility...

Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT// <Enter>

The following SCHEDULED VISITS are available:

   1>  JUN 29, 1999@08:00                          ONCOLOGY
   2>  JUN 24, 1999@11:00  NO ACTION TAKEN         ONCOLOGY
```

```
   3>  JUN 24, 1999@10:00  NO ACTION TAKEN        ONCOLOGY
   4>  JUN 24, 1999@09:00  NO ACTION TAKEN        CARDIOLOGY
   5>  JUN 24, 1999@08:00                         GENERAL MEDICINE
CHOOSE 1-5, or
<U>NSCHEDULED VISITS, <F>UTURE VISITS, or <N>EW VISIT
<RETURN> TO CONTINUE
OR '^' TO QUIT: N

PATIENT LOCATION: GENERAL MEDICINE// <Enter>
Enter Visit Date/Time:  NOW// <Enter>  (JUL 13, 2000@09:21:24)
TYPE OF VISIT: AMBULATORY// <Enter> (WALK-IN)   AMBULATORY (WALK-IN)

Enter/Edit PROGRESS NOTE...
          Patient Location:  GENERAL MEDICINE
        Date/time of Visit:  07/13/00 09:21
         Date/time of Note:  NOW
            Author of Note:  ARCENEAUX,CHARLES
   ...OK? YES//<Enter>

Calling text editor, please wait...
  1>Treatment for allergic reaction to injury.
  2><Enter>
EDIT Option: <Enter>

Saving Adverse React/Allergy with changes...
Is this Adverse React/Allergy ready to release from DRAFT? YES// <Enter>
Adverse React/Allergy Released.

Enter your Current Signature Code: <Enter Signature> SIGNATURE VERIFIED..

Select PRIMARY PROVIDER: SNOW,CHARLES R // <Enter>  SNOW,CHARLES R       CRS
   PHYSICIAN

Please Indicate the Diagnoses for which BABBITT,GEORGE F was Seen:
                         18 Ascites               34 Shoulder
 1 Abdominal Pain        19 ASHD                  MISC (2)
 2 Abnormal EKG          20 Asthma                35 DIETARY SURVEIL/COUN
 3 Abrasion              21 Atrial Fibrillat
 4 Abscess               22 Atypical Chest P
 5 Adverse Drug Reactio  23 Avulsion, Finger
 6 AIDS/ARC              BITE:
 7 Alcoholic, intoxicat  24 Animal
 8 Alcoholism, Chronic   25 Insect Bite
 9 Allergic Reaction     MISC
10 Anemia                26 Bleeding, GI
ANGINA:                  27 Blurred Vision
11 Stable                28 BPH                   45 Cirrhosis
12 Unstable              29 Bronchitis, acute     46 Conjunctivitis
13 Anorexia              BURN:                    47 Constipation
14 Appendicitis, Acute   30 First Degree          48 Contusion
15 Arthralgia            31 Second Degree         49 COPD
ARTHRITIS                32 Third Degree          50 Costochodritis
16 Osteo                 BURSITIS:                51 CVA
17 Rheumatoid            33 Elbow                 52 Cyst, Pilonidal
```

g to the clinic, as
g the AICS

Example: Entry of Progress Note, cont'd

A list of procedures

```
Select Diagnoses (<RETURN> to see next page of choices):

Please Indicate the Procedure(s) Performed on BABBITT,GEO

NEW PATIENT              16 Cardioversion         29 Smal
 1 Brief Visit           17 EKG                   DISLOCA
 2 Limited Exam          18 Pericardiocentesis    30 Elbow
 3 Intermediate Exam     19 Thoracotomy           31 Nasal
 4 Extended Exam         ENT                      32 Phalanx
 5 Comprehensive Exam    20 Removal Impacted Cer  33 Radial Head
ESTABLISHED PATIENT      NASAL CAUTERING AND      34 Shoulder
 6 Brief Exam            21 Anterior, Simple      35 Temporomandibular
 7 Limited Exam          22 Anterior, complex     36 Finger Splint
 8 Intermediate Exam     23 Posterior             37 Forearm Splint
 9 Extended Exam         EYE                      38 Injection Tendon She
10 Comprehensive Exam    24 Foreign Body Removal  LIGAMENT/TRIGGER
CONSULTATIONS             -26 PROFESSIONAL C      PULMONARY
11 Brief Visit            -32 MANDATED SERVI      39 Admin Oxygen
12 Limited Visit         25 Air ambulance servic  40 Inhalation Therapy
13 Intermediate Visit    26 PET follow SPECT      41 Peak Flow Spirometry
14 Extended Visit        ORTHOPEDIC               UROLOGY
15 Comprehensive Visit   ARTHROCENTESIS           42 Foley Catherter
                         27 Intermediate          MISCELLANEOUS
CARDIOVASCULAR           28 Major Joint (shoulde  I&D

Select Procedures (<RETURN> to see next page of choices):  (1-42): 24

43 Abcess
SIMPLE REPAIR, WOUND
44 Less than 2.5 cm
45 2.6 - 7.5 cm
46 Greater than 7.5 cm
SOFT TISSUE:
47 Burns 1 * Local Trea
48 Dressings Medium
49 Dressings Small
50 Transfusion
51 Venipuncture
52 OTHER Procedure

Select Procedures:  (1-52): 48

FOREIGN BODY REMOVAL W/ MOD W/ MOD X 2:

How many times was the procedure performed? 1// <Enter>
Current CPT Modifiers:
            -26    PROFESSIONAL COMPONENT
            -32    MANDATED SERVICES
Select another CPT MODIFIER: ??

   Choose from:
   22        UNUSUAL PROCEDURAL SERVICES
   23        UNUSUAL ANESTHESIA
   26        PROFESSIONAL COMPONENT
   32        MANDATED SERVICES
   47        ANESTHESIA BY SURGEON
   50        BILATERAL PROCEDURE
   51        MULTIPLE PROCEDURES
   52        REDUCED SERVICES
   53        DISCONTINUED PROCEDURE
   54        SURGICAL CARE ONLY
   55        POSTOPERATIVE MANAGEMENT ONLY
   56        PREOPERATIVE MANAGEMENT ONLY
   57        DECISION FOR SURGERY
```

A list of CPT Modifiers can be printed out by entering two question marks (??) at the prompt.

Example: Entry of Progress Note, cont'd

```
   58         STAGED OR RELATED PROC BY SAME PHYS DURING POSTOP PERIOD
   59         DISTINCT PROCEDURAL SERVICE
   62         TWO SURGEONS
   66         SURGICAL TEAM
   73         DISC O/P HOSP/AMB SURG CENTER (ASC) PROC PRIOR ADMIN-ANESTH
   74         DISC O/P HOSP/AMB SURG CENTER (ASC) PROC AFTER ADMIN-ANESTH
   76         REPEAT PROCEDURE BY SAME PHYSICIAN
   77         REPEAT PROCEDURE BY ANOTHER PHYSICIAN
   78         RETURN TO OP ROOM FOR RELATED PROC DURING POSTOP PERIOD
   79         UNRELATED PROC OR SERVICE BY SAME PHYS DURING POSTOP PERIOD
   80         ASSISTANT SURGEON
   81         MINIMUM ASSISTANT SURGEON
   82         ASSISTANT SURGEON (WHEN QUAL RES SURGEON NOT AVAIL)
   90         REFERENCE (OUTSIDE) LABORATORY
   99         MULTIPLE MODIFIERS
   AA         ANESTHESIA PERF BY ANESGST
   AS         PA,NP,CN ASSIST-SURG
   QX         CRNA SVC W/ MD MED DIRECTION
   QZ         CRNA SVC W/O MED DIR BY MD
   SG         ASC FACILITY SERVICE
   TC         TECHNICAL COMPONENT

Select another CPT MODIFIER: 47       ANESTHESIA BY SURGEON
Select another CPT MODIFIER: <Enter>

DRESSINGS MEDIUM:

How many times was the procedure performed? 1// <Enter>
Select CPT MODIFIER: <Enter>

Was this encounter related to any of the following:

Service Connected Condition? Y  YES

You have indicated the following data apply to this visit:

DIAGNOSES:
   995.3    Allergic Reaction  <<< PRIMARY

PROCEDURES:
   65205    Foreign Body Removal W/ Mod w/ mod x 2
        CPT Modifier(s):
            -26    PROFESSIONAL COMPONENT
            -32    MANDATED SERVICES
            -47    ANESTHESIA BY SURGEON
   16015    Dressings Medium

SERVICE CONNECTION:
   Service Connected? YES

   ...OK? YES// <Enter>

Posting Workload Credit...Done.
Print this note? No// <Enter>  NO

You may enter another Progress Note. Press RETURN to exit.

Select PATIENT NAME:
```

Visit Orientation

Why associate Progress Notes with Visits?

- **Database design:** An event (clinical or otherwise) may be fully described by five key attributes or parameters: Who, what, when, where, and why. Three of these (i.e., who, when, and where), are all encoded in the Visit File entry itself. The remaining two parameters (what, and why), are generally included in the content of the document.
-
- **The VHA Operations Manual, M-1, Chapter 5** requires that every ambulatory visit have at least one Progress Note. Deficiencies with respect to this requirement can *only* be identified if Progress Notes are associated with their corresponding Visits.
-
- **Inter-facility data transfer** requires identification of the Facility from which the data originated. Because the Facility is an attribute of the Visit file entry, it is not necessary to maintain a reference to the facility with every clinical document.
-
- **Workload Capture,** particularly for telephone and standalone encounters, where the only record of the encounter is frequently a Progress Note, can be easily accommodated, provided that notes are associated with visits.

- **"Roll-up" of documentation by Care Episode.** To allow access to all information pertaining to a given episode of care (e.g., for close-out of a hospitalization), a visit orientation is essential.

- **Integration with PCE, Ambulatory Care Data Capture, and CIRN.** The visit orientation provides a useful associative entity for interfaces with other clinical data repositories that allow query and report generation based on the existence of a variety of coded data elements. For example, a search of PCE to identify all patients with AIHD who were discharged without a prescription for aspirin prophylaxis might identify a cohort of patients for further evaluation. The ability to call for all the cardiology notes entered during the corresponding care episodes could revolutionize retrospective chart review).

Glossary

ASU — Authorization/Subscription Utility, an application that allows sites to associate users with user classes, allowing them to specify the level of authorization needed to sign or order specific document types and orderables. ASU is distributed with TIU in this version; eventually it will probably become independent, to be used by many **V*IST*A** packages.

Action — A functional process that a clinician or clerk uses in the TIU computer program. For example, "Edit" and "Search" are actions. Protocol is another name for Action.

Boilerplate Text — A pre-defined TIU template that can be filled in for Titles, speeding up the entry process. TIU exports several Titles with boilerplate text which can be modified to meet specific needs; sites can also create their own.

Business Rule — Part of ASU, Business Rules authorize specific users or groups of users to perform specified actions on documents in particular statuses (e.g, an unsigned progress note may be edited by a provider who is also the expected signer of the note).

Class — Part of Document Definitions, Classes group documents. For example, "Progress Notes" is a class with many kinds of progress notes under it.
Classes may be subdivided into other Classes or Document Classes. Besides grouping documents, Classes also store behavior which is then inherited by lower level entries.

Clinician — A doctor or other provider in the medical center who is authorized to provide patient care.

Glossary, cont'd

Component	Components are "sections" or "pieces" of documents, such as Subjective, Objective, Assessment, and Plan in a SOAP Progress Note. Components may have (sub)Compon-ents as items. They may have Boilerplate Text. Components may be designated as "Shared."
Computerized Patient Record System (CPRS)	A comprehensive **V***IST***A** program, which allows clinicians and others to enter and view orders, Progress Notes and Discharge Summaries (through a link with TIU), Problem List, view results, reports (including health summaries), etc.
CWAD	Cautions, Warnings, Adverse Reactions, Directives; a type of Progress Note.
Discharge Summary	Discharge summaries are summaries of a patient's medical care during a single hospitalization, including the pertinent diagnostic and therapeutic tests and procedures as well as the conclusions generated by those tests. They are required for all discharges and transfers from a VA medical center, domiciliary, or nursing home care. The automated Discharge Summary module of TIU provides an efficient and immediate mechanism for clinicians to capture transcribed patient discharge summaries online, where they're available for review, signing, adding addendum, etc.

Glossary, cont'd

Document Class	Document Classes are categories that group documents (Titles) with similar characteristics together. For example, Nursing Progress Notes might be a Document Class, with Nursing Dialysis Progress Notes, Nursing psychology Progress Notes, etc. as Titles under it. Or maybe the Document Class would be Psychology Notes, with Psychology Nursing Notes, Psychology Social Worker Notes, Psychology Patient Education Notes, etc. under that Document Class..
Document Definition	Document Definition is a subset of TIU that provides the building blocks for TIU, by organizing the elements of documents into a hierarchy structure. This structure allows documents (Titles) to inherit characteristics (such as signature requirements and print characteristics) of the higher levels, Class and Document Class. It also allows the creation and use of boilerplate text and embedded objects.
HIMS	Hospital Information Management System, common abbreviation/synonym used at VA site facilities; also known as MIS (see below).
IRT	Incomplete Record Tracking, a package TIU can interface with to transmit incomplete progress notes and discharge summaries.
Interdisciplinary Note	A new feature of Text Integration Utilities (TIU) for expressing notes from different care givers as a single episode of care. They always start with a single note by the initial contact person (e.g., triage nurse, case manager, attending) and continue with separate notes created and signed by other providers, then attached to the original note.
MIS	Common abbreviation/synonym used at VA site facilities for the Medical Information Section of Medical Administration Service. May be called HIMS (Health Information Management Section).

MIS Manager	Manager of the Medical Information Section of Medical Administration Service at the site facility who has ultimate responsibility to see that MRTs complete their duties.
MRT	Medical Record Technician in the Medical Information Section of Medical Administration Service at the site facility who completes the tasks of assuring that all discharge summaries placed in a patient's medical record have been verified for accuracy and completion and that a permanent chart copy has been placed in a patient's medical record for each separate admission to the hospital.
Object	Objects are a device to extract data from other **V*IST*A** packages to insert into boilerplate text of progress notes or discharge summaries. This is done by having a placeholder name embedded in the predefined boilerplate text of Titles, such as: "PATIENT AGE." The creator of the Object types the placeholder name into the boilerplate text of a Title, enclosed by '|'s. If a Title has the following boilerplate text: "Patient is a healthy |PATIENT AGE| year old male ..." Then a user who enters such a note for a 56 year old patient would be presented with the text: "Patient is a healthy 56 year old male ..." where the age for this specific patient is pulled from the patient database.
Progress Notes	The Progress Notes module of TIU is used by health care givers to enter and sign online patient progress notes and by transcriptionists to enter notes to be signed by caregivers at a later date. Caregivers may review progress notes online or print progress notes in chart format for filing in the patient's record.
TIU	Text Integration Utilities

Glossary, cont'd

Title	Titles are definitions for documents. They store the behavior of the documents which use them.
User Class	User Classes are the basic components of the User Class hierarchy of ASU (Authorization/ Subscription Utility) which allows sites to designate who is authorized to do what to documents or other clinical entities.

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